

Army Regulation 40-3

Medical Services

Medical, Dental, and Veterinary Care

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SUMMARY of CHANGE

AR 40-3

Medical, Dental, and Veterinary Care

NOTE: DA Form 7397-R (U.S. Army Medical Command Library Annual Report FY_) (prescribed in AR 40-3) can no longer be found in the back of the electronic version of this regulation. An electronic version of this form is available on the Army Electronic Library (EM0001) and the USAPA Web site (<http://www.usapa.army.mil>). DA Form 7397-R will be converted to a totally electronic form at the next revision of this regulation.

This revision dated 28 January 2002-

- o Describes the method whereby Army flight surgeons become certified by the Federal Aviation Administration to become aeromedical examiners (chap 3).
- o Defines the distinction between specialists in aviation medicine (61N9C-A) and flight surgeons (61N9D) (chap 3).
- o Provides guidance relevant to the Remote Order Entry System for procuring hearing aid batteries (chap 4).
- o Augments current policy pertinent to active duty soldiers as living organ donors (chap 9).
- o Presents implementing policy for the DOD Basic Core Formulary and provides a classification system for medication errors (chap 11).
- o Provides new policy for newly appointed civilian emergency medical technicians (EMTs) who are not National Registry for Emergency Medical Technicians (NREMT)-certified (chap 13).
- o Revises supersession, history, summary, suggested improvements, and distribution statements in the front matter.
- o Revises policy on training of flight surgeons and specialists in AVMED (para 3-1).
- o Supersedes policy on Aviation Medicine Program responsibilities (para 3-2).
- o Supersedes policy on flight surgeon clinical duties (para 3-5).
- o Supersedes policy on flight surgeon non-clinical duties (para 3-6).
- o Supersedes policy on supervision of medical care for aviation personnel (para 3-7).
- o Adds policy on Federal Aviation Administration medical examinations and certificates (para 3-9).

- o Revises policy on auditory evaluation and hearing aids (chap 4).
- o Revises policy on nutrition care management (chap 8).
- o Supersedes policy on active duty (AD) members as donors (para 9-1d).
- o Revises policy on pharmacy management (chap 11).
- o Revises policy on emergency medical technician training (para 13-3c(4)).
- o Revises list of required publications (app A).
- o Revises list of referenced forms (app A).
- o Revises policy on inventory, control, and accountability of controlled substances (app B).
- o Revises glossary sections I and II.
- o AR 40-3 revision dated 30 July 1999-
- o Supersedes paragraphs 2-11 and 2-22 and chapters 9 through 12 and 17 through 19 of AR 40-3, dated 15 February 1985. AR 40-400 dated 12 March 2001 supersedes chapters 1, 3-8, 13-16, and all portions of chapter 2 except paragraphs 2-11 and 2-22 of AR 40-3, dated 15 February 1985.
- o Defines the Aviation Medicine Program and outlines responsibilities and duties of personnel associated with this program (chap 3).
- o Decentralizes hearing aid shipment and repair (para 4-5).
- o Implements Department of Defense Directive 6000.12, Health Services Operations and Readiness, dated 29 April 1996, for the Armed Services Blood Program Office (chap 5).
- o Adds policies on the Army Blood Program formerly contained in AR 40-2, chapter 12 (chap 5).
- o Delineates Army Blood Program responsibilities for U.S. Forces Command and U.S. Army Training and Doctrine Command commanders (para 5-2).
- o Prescribes DA Form 3982 (Medical and Dental Appointment), formerly prescribed by AR 40-2 (para 6-6e).
- o Updates information on Army Medical Department medical libraries formerly found in AR 40-2, chapter 10, and provides guidance on the Army Medical Department Medical Library and Information Network (chap 7).
- o Prescribes the use of a new form and reporting requirement, DA Form 7397-R (U.S. Army Medical Command Library Annual Report FY__) (para 7--8).
- o Includes updated material on nutrition care management, formerly contained in AR 40-2, chapter 9 (chap 8).

- o Prescribes DD Form 2731 (Organ and Tissue Donor Card) (para 9-2b(2)).
- o Adds a requirement for a medical officer to test fit orthopedic footwear (para 10-5c).
- o Updates and adds policies on pharmacy management and controlled substances formerly contained in AR 40-2, chapters 7 and 8 (chap 11).
- o Prescribes the following forms formerly prescribed by AR 40-2: DD Form 2081 (New Drug Request) (para 11-6); DD Form 1289 (DOD Prescription) (para 11-12); DA Form 3875 (Bulk Drug Order) (para 11-12); DA Form 3862 (Controlled Substances Stock Record) (para 11-19); DA Form 3949 (Controlled Substances Record) (para B-5); and DA Form 3949-1 (Controlled Substances Inventory) (para B-5).
- o Adds new material on psychological test materials (chap 12).
- o Provides new standards for conducting emergency medical services (chap 13).
- o Delineates responsibilities for the operation of medical laboratories for Commander, U.S. Military Entrance Processing Command; Commander, Army Corps of Engineers; Commander, United States Army Medical Command; Commanders, Regional Medical Commands; military treatment facility commanders; and Chief, Departments of Pathology or Laboratory Services (para 14-3).
- o Implements College of American Pathologists laboratory accreditation policy previously published in Health Services Command Supplement 1 to AR 40-2. Extends accreditation requirements to fixed military treatment facility laboratories in Europe and Korea. Clarifies Joint Commission on the Accreditation of Healthcare Organizations and Commission on Office Laboratory Accreditation requirements (para 14-4).
- o Contains personnel standards for the performance of minimal, moderate, and high--complexity laboratory procedures, including provider--performed microscopy. Clarifies laboratory director requirements (para 14-5).
- o Addresses the need for a laboratory quality control plan and the requirement for quality control data collection in the subspecialty of cytopathology (para 14-6).
- o Defines individuals authorized to order laboratory tests and provides guidance concerning self performance of laboratory tests by patients in medical treatment facilities (paras 14-9 and 14-10).
- o Rescinds the use of VA Form 21-8358 (Notice to Veterans Administration of Admission to Uniformed Services Hospital).
- o Deletes the coverage of medical care entitlements that are now contained in AR 40-400. Use of trademarked names does not imply endorsement by the U.S. Army but is intended only to assist in identification of a specific product.

Medical Services

Medical, Dental, and Veterinary Care

By Order of the Secretary of the Army:

ERIC K. SHINSEKI
General, United States Army
Chief of Staff

Official:



JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army

History. This printing publishes a revision of this regulation. Because the publication has been extensively revised, the changed portions have not been highlighted.

Summary. This revision augments current policy pertinent to active duty (AD) soldiers as living organ donors. It describes the method whereby the Federal Aviation Administration certifies Army flight surgeons to become aeromedical examiners, and it defines the distinction between specialists in aviation medicine (61N9C-A) and flight surgeons (61N9D). This revision provides guidance relevant to the Remote Order Entry System for procuring hearing aids and batteries. It presents implementing policy for the DOD Basic Core Formulary and provides

a classification system for medication errors. This regulation no longer implements quadripartite standardization agreement (QSTAG) 471. Finally, this revision provides new policy for newly appointed civilian emergency medical technicians who are not certified by the National Registry for Emergency Medical Technicians.

Applicability. This regulation applies to the Active Army, the Army National Guard, and the U.S. Army Reserve. It also applies to medical department activities, medical centers, dental activities, veterinary activities, and other Army Medical Department organizations. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. Proponents may delegate the approval authority, in writing, to a division chief under their supervision within the proponent agency who holds the grade of colonel or the civilian equivalent.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated.

Supplementation. Supplementing this

regulation is prohibited without prior approval from The Surgeon General (DASG-HSZ), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Suggested Improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Headquarters, Department of the Army (DASG-ZA), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Committee Continuance Approval. The DA Committee Management Officer concurs in the establishment of the Pharmacy and Therapeutics Committee and the Medical Library Committee.

Distribution. This publication is available in electronic media only (EMO) and is intended for command levels A, B, C, D, and E for Active Army, Army National Guard of the United States, and U.S. Army Reserve.

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Glossary

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Chapter 1 Introduction

1–1. Purpose

This regulation establishes policies, procedures, and responsibilities pertaining to selected Army Medical Department (AMEDD) programs and initiatives. If any policy or procedure contained in this regulation changes current conditions of employment of civilian bargaining unit employees, the servicing Civilian Personnel Office/Civilian Personnel Advisory Center will be contacted to determine if there are bargaining obligations with recognized unions.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the Glossary.

1–4. Responsibilities

Responsibilities specific to subject areas addressed in this regulation are delineated in individual chapters and pertain only to policies and procedures described in that chapter.

Chapter 2 Advance Directives, Do-Not-Resuscitate, and Withhold/Withdraw Orders

2–1. Introduction

This chapter sets policy and procedures for the implementation of advance directives and for the initiation of orders to suspend cardiopulmonary resuscitation (do-not-resuscitate (DNR) orders) or to withhold or withdraw life-sustaining treatment.

2–2. Responsibilities

a. The military treatment facility (MTF) commander will provide operational guidance for implementation of the policies in this chapter.

b. The entire health care team (including physicians, nursing personnel, administrators, attorneys, chaplains, social workers, and patient representatives) will provide assistance with the formulation of advance directives and will help patients and their families participate in their health care decisions. The physician primarily responsible for the patient's care is ultimately responsible for ensuring that the patient has adequate information on which to base his or her decision and that the patient's wishes are honored so far as possible.

2–3. Policy

a. A patient with decision-making capacity has the legal and moral right to participate in medical care decisions, including the right to refuse medical treatment at any time even if it is lifesaving.

b. Upon admission, all adult patients will be informed in writing of their right to participate in their health care decisions, including the right to accept or refuse medical or surgical treatment, and of their right to prepare advance directives.

c. An order to resuscitate is a standing order and resuscitation will be initiated unless there is a written DNR order to the contrary.

d. When a patient will not benefit from treatment, a decision to withhold or withdraw that modality, with the concurrence of the patient or appropriate surrogate decision-maker, may be justified and must be fully and accurately documented.

e. An abatement order (see Glossary) or an advance directive shall not affect other treatment decisions. Specific attention should be paid to making respectful, responsive, and competent care available for patients who choose to forego life-sustaining treatment. Therefore, orders for supportive care should be written separately. All efforts to provide comfort and relief from pain will be provided.

f. Only physicians with clinical privileges who are members of the medical staff may write an abatement order. Physicians in a graduate medical education status can transcribe a verbal order from a privileged physician.

g. Physicians will promptly inform others who are responsible for the patient's care, particularly the nursing staff, about the abatement decision. All who are responsible for the patient's care should clearly understand the order, its scope, its rationale, and its implications.

2–4. Documentation

a. *Advance directives.*

(1) The presence or absence of an advance directive and/or the opportunity for the patient to formulate an advance directive will be documented as part of the admission process. Documentation should be included in the admission clerk's checklist, the nurse's intake assessment, and in the progress notes.

(2) A copy of the advance directive, if any, will be placed in the inpatient chart. (See AR 40-66.)

(3) A patient shall not be coerced into formulating an advance directive.

b. Abatement orders.

(1) Documentation of the progress notes will explain the medical rationale for the order. It will also show the patient's decision-making capacity and the concurrence of the patient or surrogate. Any review and consultation by an ethics committee will also be documented. (Note: If an ethics committee exists, notify the U.S. Army Medical Command (USAMEDCOM): Commander, USAMEDCOM (MCHO-CL-C), 2050 Worth Road, Fort Sam Houston, TX 78234-6010. The notification should include complete contact information for the committee chairperson and committee membership requirements.) Finally, any discussion with the patient or appropriate surrogate will be summarized in the progress notes. In no instance will the patient or surrogate be asked to sign any type of 'release.'

(2) The order will be written on the doctor's orders sheet and will be dated and signed.

2-5. Review

Advance directives and abatement orders will be reviewed routinely on rounds and whenever there is a significant change in the patient's condition. If the patient is being considered for major invasive procedures (such as operations) the indications for the procedure and the rationale behind the intervention and the patient's wishes will be reviewed. Abatement orders will stand unless rescinded either by the attending physician (verbal orders will be accepted), or at any time when a patient with decision making capacity or the surrogate makes this request known to any health care provider responsible for the patient's care. Rescission of the order will be documented as outlined in paragraph 2-4.

2-6. Abatement decisions for patients with decision-making capacity

a. The voluntary choice of a capable and informed patient will determine whether life-sustaining treatment will be undertaken.

b. In an attempt to respect their wishes, patients should be given the opportunity to formulate advance directives covering their preferences for end-of-life decisions. The attending physician shall discuss advance directives with the patient, preferably in advance of the critical situation.

c. If a patient requests an abatement order after full discussion and assessment of risks and benefits, the attending physician will enter the order in the patient's medical record. When the physician finds the patient's preference to be morally unacceptable and is unwilling to participate in carrying out the request, he or she should transfer responsibility for the patient to another physician.

d. The patient will be asked if his or her family may be informed of the advance directive or abatement order. If consent is granted, the family will be informed but will not be permitted to override the patient's decision. Where the capable patient requests that family members not be involved in or informed of his or her decision, the patient's decision and request for confidentiality will be honored and documented in the medical record. This documentation will be made by a person who is not a member of the treatment team.

2-7. Abatement decision for incapable patients

a. While capable of making decisions, patients may envision their later incapacity and deteriorating medical condition. Such patients may have made firm and explicit verbal or written directives regarding their wishes. Such directives should be discussed with the surrogate and should be honored.

b. An incapable patient may have no surrogate and the treating staff may feel that an abatement order is proper. If so, consultation should be undertaken with the ethics committee, if available, and the supporting judge advocate and documented.

c. Determining the patient's decision making capacity, informing the surrogate, and helping the surrogate to decide may require time that is not available in an emergency. In general, therefore, because of its grave nature and consequences, abatement decisions should be made under conditions that permit consultation and reasoned decision. In an emergency, treatment should ordinarily be given if no prior decision has been made to forego life-sustaining treatment.

d. After assessment of the benefits and risks, if there is agreement between the attending physician and the patient's surrogate, an abatement order will be entered in the patient's medical record. When a patient's surrogate disagrees, the case should be carefully reviewed by an ethics committee or other mechanism as defined by the local MTF commander. Every effort should be made to build consensus between the health care team and the surrogate.

2-8. Education

The education of health care professionals should include training on the patient's right to make an advance directive as well as to assist the patient and/or surrogate in making ethically supportable end-of-life decisions.

2-9. Active duty patients

While active duty (AD) patients usually determine their own care, occasionally the requirements of the Service will override their decision. These situations are unusual but when questions concerning mandatory medical or surgical procedures on AD soldiers arise, they should be referred to the Office of the Judge Advocate for guidance on a case-by-case basis and resolution (AR 600-20).

2-10. Additional guidance

Questions concerning implementation of this policy should be directed to Commander, USAMEDCOM (MCHO-CL-C), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

Chapter 3

Army Aviation Medicine Program and Medical Care of Aviation Personnel

3-1. Program concept

The Aviation Medicine (AVMED) Program is designed to promote and maintain the aviation fighting force through health promotion and sustainment of the mental and physical wellbeing of aviation personnel. Flight surgeons (61N9D) are graduates of the Army Flight Surgeon Primary Course and perform routine AVMED duties. They are generally assigned to battalion or squadron level. Specialists in AVMED (61N9C, B, A) are residency-trained in aerospace medicine. This training includes earning a master's degree in public health plus additional study in preventive, occupational, and environmental medicine factors as they apply to the aviation environment. They are generally assigned to brigade or regiment level and above, according to their seniority, and perform additional supervisory functions in the AVMED Program.

3-2. Responsibilities

a. The Surgeon General (TSG) is responsible for training, development, fiscal planning, and oversight of Department of the Army (DA) policies and programs for the AVMED Program.

b. All major Army command (MACOM) commanders are responsible for enforcing the regulatory aspects of AVMED within their commands.

c. The AVMED consultant (to TSG) will assist TSG in policy formulation and provide technical supervision of all aspects of the AVMED Program.

d. Regional Medical Command (RMC) commanders will—

(1) Ensure implementation of the AVMED Program.

(2) Assign a residency-trained specialist in aerospace medicine as RMC Chief, AVMED. When a specialist is not available, an experienced flight surgeon (FS) will be temporarily assigned until a specialist is made available.

e. The RMC Chief, AVMED will oversee the RMC AVMED Program and act as the RMC advisor for aeromedical policies and issues such as FS deployments, aeromedical evacuation policy, and regional review and disposition of flight physicals.

f. The Commander, U.S. Army Aeromedical Center, will—

(1) Direct and supervise the U.S. Army Aeromedical Activity and Lyster Army Community Hospital in order to provide worldwide support of Army AVMED programs through consultations, supportive services, and training in the areas of aviation and military occupational disease prevention, surveillance, and evaluation.

(2) Review and recommend dispositions of flying duty medical examinations (FDMEs) and medical waiver requests for continued flying duty according to AR 40-501. (Also see DA Form 4186 (Medical Recommendation for Flying Duty) as prescribed in AR 40-501.)

(3) Develop and update FDME practices and policies through the publication of aeromedical policy letters and aeromedical technical bulletins (according to AR 40-501).

(4) Develop and maintain the Aeromedical Epidemiological Data Repository to support research and clinical studies for aircrew medical standards and policy.

(5) Be the designated medical advisor to the Commanding General of the Aviation Center and Chief of the Aviation Branch.

g. The Commander, U.S. Army Safety Center, will direct the safety center surgeon to investigate human factors in aviation safety, aircraft design, and aviation mishaps.

h. The Commander, U.S. Army Aeromedical Research Laboratory, will—

(1) Conduct research and development of aviation life support equipment and aircrew protection.

(2) Conduct research in the effects of exogenous aeromedical factors in the aviation operational environment.

i. The Dean, U.S. Army School of AVMED, will—

(1) Be responsible for all aspects of AMEDD and U.S. Army Training and Doctrine Command aeromedical education and training, including developing advanced aviation medicine qualification training and conducting the

Army aerospace medicine residency and the annual professional short course (Combined Operational Aeromedical Problems Course).

(2) Supervise the aeromedical portion of the aviation resources management survey.

j. The installation medical authority (MTF commander) of installations hosting both Active Component and Reserve Component (RC) aviation assets will—

(1) Establish, supervise, administer, and support the AVMED Program.

(2) Appoint a senior installation FS or aeromedical physician assistant as Chief, AVMED.

(3) Ensure that the AVMED Program is included in the MTF's specific improving organizational performance (IOP) structure.

k. The chief of AVMED will oversee the installation AVMED Program and coordinate the efforts of the aviation medicine team consisting of aviation psychology, dentistry, and optometry.

l. Unit-level FS responsibilities are described in paragraphs 3-5 and 3-6.

3-3. Aeromedical physician assistant

Aeromedical physician assistants will be under the supervision of an FS, and their duties will be as prescribed by AR 40-48.

3-4. Flight medical aidman

The flight medical aidman is trained and supervised to provide—

a. Medical aidman crew duties for air ambulance operations.

b. The basics of emergency medical care.

c. Administrative support of the AVMED clinic.

3-5. Flight surgeon clinical duties

a. *Primary care.* The FS will—

(1) Provide routine primary medical care to all unit aviation and aviation support personnel.

(2) Ensure appropriate maintenance of medical records on all aviation personnel, including air crewmembers in non-operational assignments even if not on active flying duty (on flight status). He or she will maintain a tracking mechanism to ensure aeromedical documents such as FDMEs, DA Forms 4186, and so forth, arrive at their proper destinations. He or she will also ensure aviation medical records are included in all supervising MTF health record (HREC) quality assurance programs.

(3) Provide an AVMED primary care program, including health promotion and preventive medicine, for aviation personnel family members when mission requirements, staffing, and facilities can support such a program.

(4) Within the constraints of the local MTF, monitor and support the mental and physical wellbeing of aviation personnel, family members, and support personnel.

(5) Review care provided by other health care providers for impact on the flight status of aviation personnel.

b. *Preventive medicine/occupational health.* The FS will—

(1) Promote the health and safety of aviation personnel by instituting a health education program and monitoring the conditions and hazards present in the work environment. The FS will advise the command when potential safety problems are identified through participation in the Aviation Command Safety Council Program (per AR 385-95).

(2) Monitor aviation occupational hazards in accordance with established Army programs such as the Hearing Conservation Program and the Occupational Vision Program, as described in AR 40-5 and AR 385-95.

(3) Assist unit Aircrew Life Support Equipment shop with Class VIII support and survival education.

c. *FDMEs.* The FS will—

(1) Conduct FDMEs as prescribed by AR 40-501 and applicable aeromedical policy letters and technical bulletins as well as other special medical examinations when indicated.

(2) Review and monitor all FDMEs performed by other health care providers.

d. *Aeromedical consultation.* The FS will—

(1) Ensure that an on-call service for aeromedical emergencies and aeromedical evacuation consultations is in place during all hours of flight operations.

(2) Interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly.

(3) Establish procedures whereby air crewmembers are automatically grounded when treated in the emergency center (EC) or specialty clinic. Protocols should then require grounded air crewmembers to report to the FS as soon as reasonably possible.

(4) Medically clear air crewmembers for further flight duty following temporary medical disqualification or aircraft mishap.

(5) Ensure timely evaluation of aviation personnel who are medically disqualified.

3-6. Flight surgeon non-clinical duties

(Also see AR 385-95.)

a. Liaison. The FS will—

- (1) Serve as a liaison between the medical and aviation elements and act as an advocate for the AVMED Program.
- (2) Act as a special staff member on the aviation commander's staff.
- (3) Serve as a member of, or a medical consultant to, flight evaluation boards, according to AR 600-105.

b. Readiness and mobility support planning. The FS will—

- (1) Assist in medical staff planning activities associated with tactical aviation operations.
- (2) Review aviation operations plans (OPLANS), including individual aviation training, team training, and tactical field exercises to determine whether aeromedical factors that may adversely affect unit operations exist and ensure that these factors are considered in future OPLANS revision.

(3) Monitor aircrew and advise the commander of physiological and psychological factors affecting aviation operations.

(4) Recommend policies and procedures pertaining to exposure and decontamination of aviation personnel operating in the vicinity of hazardous agents.

(5) Support the aviation commander's Fighter Management (air crewmember endurance) Program.

(6) Conduct a semiannual accident prevention survey of the AVMED Program as required by AR 385-95.

c. Air crewmember aeromedical training program. The FS will assist unit commanders in developing an air crewmember aeromedical training program to meet specific operational needs of the unit. He or she will also assist in conducting unit mission analyses to determine special aeromedical training requirements as described in FM 3-04.301 (formerly FM 1-301).

d. Air ambulance operations. The FS will—

(1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft.

(2) Participate in actual air evacuation missions as appropriate.

e. Accident investigation board. The FS will—

(1) Serve as a member of, or medical consultant to, any accident investigation boards as determined by the commander and per AR 385-95 and DA Pam 385-40.

(2) Participate actively in the board proceedings, including deliberations and drafting findings and recommendations.

(3) Organize and report on special medical consultations as required by the accident investigation board when human factors or medical laboratory findings are involved in the proceedings.

f. Flight line operations. The FS will—

(1) Assist in aeromedical occupational inspections.

(2) Conduct aeromedical briefings held for both officer and enlisted personnel at unit-level training or aviation safety meetings.

(3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan as described in AR 385-95 and AR 40-21.

(4) Observe flight operations in order to monitor physical and psychological stresses that contribute to fatigue and human error in the flight environment.

(5) Participate in unit field training exercises and unit day-to-day flight activities.

(6) Participate in an operational capacity as an air crewmember in flight in each type of aircraft assigned to supported units. An FS's operational capacity will include observing flight crewmembers, monitoring patients, etc. Flight will be in all flight environments—including emergency procedures—and mission profiles (for example, nap of the earth, night vision goggles, etc.) according to AR 95-1 and AR 600-105. Flight simulators should be used in units that cannot accommodate an FS as a crewmember due to training and qualification requirements (for example, those with attack and scout aircraft). The purpose of this simulator time is to ensure that FSs understand the mission profiles and stresses of the aviators that they support. Flight simulator time does not count toward meeting the aviation career incentive pay (ACIP) flying hour requirement.

3-7. Supervision of medical care for aviation personnel

All aviation personnel will be provided ambulatory care by or under the direct supervision of an FS. If such care is not available locally, an FS may be placed on temporary additional duty orders to remotely supervise AVMED operations provided by local, non-FS health care providers. The arrangement must be approved and monitored by the RMC Chief of AVMED. (See para 3-2*d*.) The shortage condition must be rectified as soon as possible and may not be seen as a lasting solution. Non-FS providers are not authorized to provide the full spectrum of AVMED required by AR 385-95

or AR 95-1. The supervising FS and the non-FS health care providers will ensure adherence to the requirements in paragraph 3-8*a* and *b*.

3-8. Fitness for flying duty

a. When Army aviators and other personnel are on flight status, their fitness for flying duty must be determined according to AR 40-501 and AR 40-8. Admission to an MTF or being placed on 'quarters' status, dental treatment requiring agents with systemic effects, and conditions specified in the above regulations are causes for removal from flight status. (See AR 600-105.) The MTF will notify the person's commander by means of DA Form 4186 as prescribed in AR 40-501. For aviators in non operational flying jobs, DA Form 4186 is not required but all other procedures stated above apply.

b. Medical personnel administering or prescribing any type of treatment or evaluating any health-related condition of aviation personnel will ensure that proper entries are made in their patient's health records (HRECs). They will also refer their patients (with records) to an FS for further evaluation. However, aviators in non-operational flying jobs who have minor temporary conditions need not be referred to an FS.

3-9. Federal Aviation Administration (FAA) medical examinations and certificates

a. General.

(1) This paragraph establishes procedures by which Army FSs become designated FAA aviation medical examiners (AMEs) and by which personnel listed in paragraph 3-9*b* may be given a medical examination for the issuance of a second-class or third-class Federal Aviation Administration medical certificate.

(2) The following personnel may be given FAA medical examinations:

(*a*) Commissioned officers and warrant officers on AD with the Army who are designated Army aviators.

(*b*) Army personnel who are performing or may perform military air traffic control duties and who desire FAA certification or for whom such certification is desired.

(*c*) Designated Army aviators of the Army National Guard and designated Army aviators in the Army Reserve Aviation Officer Training Program.

(*d*) Civilian flight instructors and test pilots employed by DA.

(*e*) Non-rated Army personnel who currently hold valid second- or third-class FAA medical certificates or who desire to obtain such certificates.

(*f*) Other personnel eligible under DOD or DA medical programs.

b. Designated Army aviation medical examiners.

(1) TSG, through the consultant for AVMED, may request the Manager, FAA Aeromedical Education Division, to assign an Army FS a designation number to permit issuance of second- and third-class FAA airman medical certificates and combined medical/student pilot certificates and to authorize the conduct of certification examinations at specified military clinics. The procedures for application, notification, and conditions of appointment are described in DOT FAA Order 8520.2E, Aviation Medical Examiner System, located in the FAA Guide for Aviation Medical Examiners. This guide is available from the Manager, FAA Aeromedical Education Division. (Also see para 3-9*f*(1).)

(2) It is FAA policy to assess the performance of designated FSs and to terminate their designation, if appropriate. Designation of a military FS to conduct FAA examinations as an AME will terminate when he or she leaves Government service. Reports of AME performance and notification of changes in designation status will be provided by the Manager, FAA Aeromedical Education Division, to the designated FS and to the consultant for AVMED, if applicable. It is the responsibility of the military AME to report changes in his or her status or location to the FAA.

c. Examinations. Designated military AMEs will conduct medical examinations for personnel coming within the scope of this section, subject to availability of time, personnel, and facilities as determined by the commander. Military AMEs are prohibited from using their designation number to conduct FAA examinations outside of the military such as while performing off-duty employment or, in the case of RC physicians, in their civilian practice.

d. Authority to issue certificates. By agreement with the FAA, authority to issue class-2 or class-3 medical certificates is delegated to the certified military AME. Upon successful qualification, applicants will be issued class-2 or class-3 FAA medical certificates in accordance with the provisions of the FAA Guide for Aviation Medical Examiners.

e. Disposition of examination reports. Upon completion of examination, whether or not the candidate is qualified, the completed FAA Form 8500-8, (Application for Airman Medical Certificate or Airman Medical and Student Pilot Certificate) will be sent directly to the FAA using either the FAA's encrypted internet Web site or the return self-addressed envelope supplied for this purpose. Personnel may also transmit the exam via the internet at www.cami.jccbi.gov. There is a link to the FAA Aeromedical Certification Subsystem support page on the Civil Aeromedical Institute (CAMI) home page that contains useful information regarding the internet transmission of FAA physical exams.

f. Supply of FAA publications.

(1) The FAA Guide for Aviation Medical Examiners, FAA-8500-8, and other required miscellaneous forms will be

distributed by the FAA directly to facilities concerned. The FAA 8500-8 forms are serially numbered and assigned to individual military AMEs. They must be treated as controlled forms.

(2) Requests to restock these items will be made by the authorized designee to Manager, FAA Aeromedical Education Division, by using the requisition card (AC Form 8500-33 (Medical Forms and Stationary Requisition)). Contact information is located on the reverse of this card.

Chapter 4

Auditory Evaluation and Hearing Aids

4-1. Auditory evaluation and treatment facilities

This chapter establishes policy for auditory evaluations, hearing aids, and aural rehabilitation services for eligible beneficiaries. Patients will be referred for these services to the facilities listed in paragraphs a through c below. Referrals will be based on professional considerations, mission requirements of the MTF, organizations supported by the MTF, travel economy, and the time required to obtain evaluation and treatment. AR 40-400, chapter 3 and appendix B, further describes which persons are eligible to receive hearing aids provided by Army MTFs.

a. Basic hearing test clinics.

(1) *Designation.* Any MTF capable of administering pure-tone audiometry may be considered a basic hearing test clinic (BHTC).

(2) *Services provided.* BHTCs will conduct audiometry for physical examinations and hearing conservation programs. Persons with hearing levels poorer than H-1 standards (as defined in AR 40-501) will be retested to confirm the hearing loss. Persons with confirmed or suspected hearing loss compatible with an H-3 or H-4 profile will be referred by the BHTC for further evaluations, profiling, or treatment to the nearest MTF with an audiologist holding privileges to provide independent clinical services noted in paragraph b(2) below. Persons with confirmed or suspected hearing loss compatible with an H-2 profile (as defined in AR 40-501) may be profiled at the BHTC, if qualified Medical Corps personnel are available.

b. Auditory diagnostic clinics.

(1) *Designation.* Any MTF with an assigned audiologist holding privileges to provide independent clinical services noted in paragraph (2) below may be considered an auditory diagnostic clinic.

(2) *Services provided.* Auditory diagnostic clinics provide complete diagnostic auditory examinations to aid medical personnel in determining the site of lesion and etiology of hearing loss. Services include pure-tone audiometry, speech audiometry, special auditory and vestibular tests, tests for pseudohypacusis (that is, non-organic or functional hearing loss), hearing aid evaluations, hearing aid issue and replacement, aural rehabilitation, and counseling for individuals with a hearing loss or parents of children with hearing loss. Audiologists may approve hearing profiles for persons with hearing loss compatible with H-2 standards, act as profiling officers to initiate profiles for individuals with hearing loss compatible with H-2, H-3, or H-4 standards, and conduct speech recognition in noise test to assess and make recommendations for soldiers with H-3 profiles (as defined in AR 40-501).

(3) *Special auditory and vestibular services.* RMC commanders will determine requirements for additional special auditory and vestibular services at individual MTFs within their command based on recommendations from the RMC audiology consultant.

c. U.S. Army Audiology and Speech Center. The U.S. Army Audiology and Speech Center (AASC) represents the highest echelon of auditory evaluation and treatment in the AMEDD. The AASC coordinates Army clinical audiology programs, conducts basic and applied research, and provides consultation for hearing aid programs, aural rehabilitation, and clinical audiology services. The AASC also provides the services of an auditory diagnostic clinic.

4-2. Disposition of patients with hearing impairment

a. AD personnel examined for separation or retirement and found to have hearing compatible with H-3 and H-4 profiles may be evaluated at any auditory diagnostic clinic or the AASC, according to AR 40-501 and AR 635-40.

b. Patients with temporary hearing loss (for example, middle ear disease) will receive medical treatment according to local policy before a hearing profile is issued.

4-3. Procurement of hearing aids

The procurement of hearing aids for AD personnel will be limited to those instruments approved by the Department of Veterans Affairs (VA) and included on the VA purchasing contract unless the instrument required for a patient is not on the VA contract. Hearing aids should be purchased with a two-year warranty. Procurement will be made by the medical supply officer (MSO) based on specifications from the MTF audiologist.

4-4. Records of hearing aid issue

When a hearing aid is issued, the following information will be entered in the patient's outpatient treatment record (OTR): make, model, and serial number of the hearing aid issued; date of issue; and, if applicable, any modifications or

control settings that alter the acoustical output of the hearing aid. This record will be used to support subsequent hearing aid repairs and follow-up services.

4-5. Repair and replacement of hearing aids

a. Hearing aid repairs will be provided worldwide through the nearest MTF. The audiologist, trained audiology support staff, MSO, or authorized representative, will check the batteries and electrical or mechanical contacts of a malfunctioning or defective hearing aid.

(1) Inoperable hearing aids covered by manufacturer's warranty will be sent by the MTF directly to the manufacturer for repair.

(2) Inoperable hearing aids no longer covered by the manufacturer's warranty will be sent for repair through local service contracts. When local service contracts are not feasible, the hearing aid may be shipped to the AASC, Walter Reed Army Medical Center, Washington, DC 20307 with the following information: user's name, grade, social security number (SSN), home address, telephone number, date of issue, location of MTF issuing hearing aid, and a full description of the defect or complaint.

b. When a hearing aid cannot be repaired, the AASC or MTF will notify the user and recommend a hearing re-evaluation at the nearest MTF. A three-month supply of hearing aid batteries will be provided with each hearing aid at time of initial issue. A reasonable stock of batteries will be maintained for, and issued to, AD hearing aid users by their MTF. Consideration should be given to maintaining a small stock of batteries for mobilization missions supported by the MTF. Hearing aid batteries can be obtained from the Department of Veterans Affairs Denver Distribution Center (DDC). Hearing aid batteries can also be provided by the DDC directly to AD Army personnel who are assigned to remote locations (more than 50 miles from an MTF), provided the soldier's hearing aid is registered in the VA Remote Order Entry System (ROES). In order to register a soldier's hearing aid in the ROES, the soldier's name, grade, social security number, and the name of the MTF that has confirmed the soldier is still on AD and eligible for care, must be submitted to the RMC's primary audiology clinic (usually at the medical center level). The RMC's primary audiology clinic has access to, and will register the hearing aid in, the ROES. The AASC will coordinate this program and funding support for hearing aid batteries procured from the DDC for soldiers assigned to remote locations

4-6. Accountability and responsibility

a. Each individual receiving a hearing aid will acknowledge, in writing, receipt of the hearing aid at the time of issue.

b. Individuals will report any loss or damage of hearing aids to the MTF's audiologist, MSO, or designated representative. If it is suspected that the loss, damage, or destruction of a hearing aid is due to the user's misconduct, pecuniary liability will be determined. If indicated, a reimbursement will be made to the Government for such loss, damage, or destruction.

Chapter 5 Army Blood Programs

5-1. General

This chapter addresses the command blood programs and the Army Blood Program, and their relationships with the Armed Services Blood Program, other uniformed services' blood programs, civilian blood programs, National Blood Policy, and the National Emergency Blood Program. This chapter implements Department of Defense Directive (DODD) 6000.12 for the Armed Services Blood Program Office (ASBPO) and pertains to all Army blood collection and transfusion facilities.

5-2. Responsibilities

a. TSG will-

(1) Manage the ASBPO and provide administrative support for its internal administration and operation according to AR 10-64/OPNAVINST 6700.2/AFR 160-29/MCO 5420.18A.

(2) Program, budget, and finance all costs of operations of the ASBPO and its staff, except the pay, allowances, and permanent change of station travel of military personnel members and assigned staff which are the responsibility of the military department providing the military personnel.

(3) Fund for blood procurement from civilian sources including the costs of transportation to the appropriate Armed Services Whole Blood Processing Laboratory (ASWBPL) when overall military requirements exceed the organic capability of the military services. However, nothing shall preclude a service from obtaining local purchases of blood in any emergency where time or other considerations make such purchase desirable.

(4) Conduct research and develop programs devoted to progress and improvement in the areas of blood, blood derivatives, and plasma volume expanders including related techniques, facilities, and material according to policy

guidance from the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) and the Under Secretary of Defense for Research and Engineering.

(5) Appoint the holder of the DA establishment and product licenses as specified in the Memorandum of Agreement (MOA) between the Food and Drug Administration (FDA) and the Department of Defense (DOD).

b. Commanders, U.S. Army Training and Doctrine Command and U.S. Army Forces Command will-

(1) Formally establish a donor blood program.

(2) Use their own units, subordinate units, and tenant units to provide volunteer donors at the frequency and in sufficient quantity to enable Army MTFs to maintain a working inventory of blood for treatment needs.

(3) Provide maximum support and resources to meet critical blood quotas assigned to the USAMEDCOM blood donor centers during contingencies and/or mobilization periods.

c. The Commander, USAMEDCOM will-

(1) Provide policy guidance, hold and manage the DA FDA license, and provide technical oversight of the Army Blood Program.

(2) Provide the necessary blood donor centers and medical/technical personnel in support of the Army Blood Program.

(3) Provide and operate in compliance with terms of the FDA license-designated donor centers, manufacturing locations, and specifically designated products.

(4) Ensure that unlicensed (registered only) USAMEDCOM treatment facilities operate within the standards promulgated in Current Good Manufacturing Practices for Blood and Blood Components in Title 21, Code of Federal Regulation, parts 210, 211, and 600-680 (21 CFR 210, 211, 600-680) and those standards set forth by the American Association of Blood Banks (AABB) according to FM 8-70/NAVMED P-5120/AFMAN 41-111 and/or TM 8-227-3/NAVMED P-5101/AFMAN 41-119.

(5) Provide the requisite blood donor collection and manufacturing services from AMEDD resources or arrange for these services from other approved sources.

d. The Army Blood Program Manager will-

(1) Coordinate blood program operations with the blood program managers at DOD and other service levels, and, as appropriate, with other Federal and civilian agencies having blood programs.

(2) Coordinate and establish procedures and guidelines for USAMEDCOM activities related to-

(a) The procurement and exchange (resource sharing) of indated blood and blood components.

(b) The disposal of outdated blood and/or blood components.

(3) Establish quotas at USAMEDCOM activities for the manufacture and distribution of blood and blood components during readiness and mobilization according to the USAMEDCOM Base Mobilization Plan (Unclassified).

(4) Establish accounting procedures with civilian agencies that handle the resource sharing of blood, blood components, and/or blood credits.

(5) Establish periodic operational reports and reporting procedures.

(6) Provide recommendations to TSG on research and development requirements that ensure continued progress and improvement of blood banking techniques, procedures, equipment, and material.

(7) Act as Alternate Responsible Head of the DA FDA blood banking license by-

(a) Serving as the sole point of contact between the Army facilities and FDA on licensing and operational issues.

(b) Standardizing blood banking practice within the Army's FDA license.

(c) Processing all correspondence pertaining to the FDA license to include but not limited to error/accident reports, inspection findings and responses, license applications, license amendments, license supplements, etc.

(d) Overseeing the quality improvement program for the Army Blood Program according to FDA requirements.

(8) Provide guidance and approval of locally negotiated MOAs with civilian blood collection agencies on DA installations. (A sample template for such an MOA is available on request from the Army Blood Program Office.)

(9) Oversee, perform, and maintain data for the U.S. Army HIV Look-Back Program as required by Federal and DOD policy.

e. RMC commanders will-

(1) Develop and monitor the U.S. Army Blood Program at a regional level.

(2) Provide and/or arrange for consultation services and mutual blood support agreements among hospitals within the region.

(3) Program periodic staff visits to member hospitals of the region to assist in licensing and accrediting of their blood banks by the FDA and AABB, respectively.

(4) Ensure that RMC blood managers conduct at least one evaluation visit biannually to all FDA licensed medical department activities (MEDDACs) within their region. The purpose of the visit is to comply with FDA guidelines to ensure management is exercising control over all blood banking activities within the Army's U.S. license.

(5) Ensure that all evaluations performed are reported through normal channels to the U.S. Army Blood Program

Manager, USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, as the Alternate Responsible Head for the FDA license.

- (6) Monitor and recommend movement of blood inventories among hospitals within the region to-
 - (a) Reduce outdating of blood and components.
 - (b) Provide for individual MTF shortfalls in blood inventories and emergencies.
- (7) Maximize the use of the regional donor resources.
- (8) Provide for the AABB National Blood Exchange (NBE) services for member hospitals of the region.
- (9) Appoint an NBE participant within their region to assist the MEDDAC installation blood program by providing for the transfer of blood credits on behalf of the MEDDAC as required.
- f. Commanders, USAMEDCOM installations and activities having an assigned blood program mission will-
 - (1) Operate blood banks and blood donor centers to support the U.S. Army Blood Program as approved by the Army Blood Program office.
 - (2) Effect coordination with and provide support for designated USAMEDCOM activities not having blood donor center capability to ensure-
 - (a) An adequate supply of blood and blood components are provided by the most practical and efficient means making every effort to minimize outdating of blood or blood products.
 - (b) Blood donor resources are utilized to the maximum extent possible. This may include joint blood donor operations conducted by USAMEDCOM activities, operations in coordination with other uniformed services, and/or operations conducted in coordination with civilian blood agencies.
 - (3) Coordinate and assist the installation in the planning of all military blood donor drives and offer assistance and support to hospital commanders on installations not having a blood donor center.
 - (4) Ensure that all blood drives are coordinated with the commander of the installation, organization, or agency who controls the donor population to ensure blood donor operations do not conflict with appropriate operational and training missions.
 - (5) Promote an installation blood program regulation to include the designation of a committee consisting of key members from organizations scheduled to donate blood for the purpose of assisting the responsible commander in planning and conducting routine blood drives, assigning quotas, and responding to emergency requirements.
 - (6) Publicize all favorable results of donor drives to ensure that donors and their organizations are aware of the success of their participation in the U.S. Army Blood Program.
 - (7) Publish administrative directives addressing those actions necessary to-
 - (a) Transfer blood or blood components between regional activities or through appropriate civilian programs.
 - (b) Provide for emergencies requiring blood or blood components.
 - (8) Coordinate negotiations with civilian agencies for the procurement, sale, and exchange of blood and blood components with final approval of such written agreements by the Army Blood Program Manager.
 - (9) Consolidate and forward electronically to the Patient Administration Systems and Biostatistics Activity (PASBA) the quarterly blood program operational reports through the Regional Blood Program Manager Coordinator. (PASBA will provide current electronic mail addresses.)
 - (10) Maintain an ongoing donor recruitment and educational program on the host installation and, if requested, assist similar programs on other installations.
 - (11) Establish and implement U.S. Army Blood Program standardized policies and procedures as well as operating procedures which may be unique to each site. These will include but are not limited to-
 - (a) Donor selection, blood production, processing, and quality control procedures.
 - (b) Maintenance of donor, patient, compatibility, and transfusion records which clearly establish an audit trail. Such records will be maintained at least 5 years past the expiration date of blood products manufactured according to 21 CFR.
 - (c) Mutual support arrangements to include copies of written agreements.
 - (d) Provision for an adequate inventory to meet operational requirements.
 - (e) Resource sharing MOA for both indate and expiring products.
 - (12) Provide facilities, staffing, and funding of their blood banking elements commensurate with mission and regulatory requirements.
 - (13) Designate in writing a quality assurance (QA) coordinator.
 - (14) Ensure appropriate MOAs with civilian blood collection agencies are in force as required by DOD policy.
 - g. Unit commanders will-
 - (1) Develop and maintain a program of donor motivation and education. The award of time off for 'exceptional performance of duty' to military personnel who donate blood is encouraged. Additionally, all DOD health care beneficiaries should be encouraged to donate. (See para 5-3d(5).)
 - (2) Be responsible for ensuring that the organization issuing the identification card (DD Form 2A (Active Duty

Military ID Card)) and identification tag is informed of the correct blood group and type so that they may be properly recorded on the soldier's identification card and tag.

(3) After coordinating with the responsible blood donor center, ensure that student/trainee groups located within a blood donor center's collection area include time for blood donations in their training schedules.

h. The MTF commander is responsible for the proper performance of the blood grouping and typing tests and will ensure that personnel performing the tests are properly trained and supervised. This typing will be performed using forward and reverse typing procedures according to Clinical Laboratory Improvement Program (CLIP) standards.

i. Installation commanders of other MACOMs must establish an installation blood program and provide blood donors to MTFs conducting blood donor center operations. Blood donor resources will be made available to blood donor centers operating in support of installation, area, or regional missions.

5-3. Policy

a. The DA will-

(1) Operate an Army Blood Program.

(2) For all patients receiving care in its MTFs, provide blood and blood component requirements from its own resources without adverse impact on blood programs in civilian communities.

(3) Restrict peacetime DOD blood donor center blood collections to military installations except during periods of national emergency, mobilization, or war.

b. The U.S. Army Blood Program will-

(1) Provide for the blood requirements of USAMEDCOM facilities by the most efficient and cost effective means possible, consistent with established Federal regulations and approved blood banking principles and practices (for example, 21 CFR 211, 212, and 600-699; TM 8-227-3/NAVMED P-5101/AFMAN 41-119; and FM 8-70/NAVMED P-5120/AFMAN 41-111).

(2) Provide for the most effective utilization of blood donor resources and blood inventories at U.S. Army installations supported by the USAMEDCOM with an outdate rate goal of less than 5 percent for red blood cells for continental United States (CONUS) facilities. Facilities outside CONUS may have outdate rates slightly higher due to readiness concerns.

(3) Provide the capability to rapidly expand to meet readiness and mobilization blood requirements established for the program by the ASBPO and Army leadership.

(4) Ensure the integration of the U.S. Army Blood Program with the blood programs of the other Services under lead agent initiatives.

(5) Ensure that all USAMEDCOM blood banks and transfusion services meet or exceed the highest accepted standards for the operation of such services, and are accredited by the AABB.

(6) Comply with requirements of the DOD CLIP.

(7) Obtain/maintain FDA licensure for blood collecting and manufacturing facilities under procedures established by the DOD, Office of The Surgeon General (OTSG), and the USAMEDCOM in coordination with the FDA.

(8) Operate in a current good manufacturing practices environment as required by the FDA.

(9) Interface with civilian regional/community blood programs when it does not adversely affect the U.S. Army Blood Program. MOAs should be established within current guidelines to delineate current local relationships with civilian blood programs. MOAs with civilian blood collection agencies should be reviewed biannually and copies provided to the Commander, USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010. MOAs must meet all requirements of ASD(HA) policies and directives.

(10) Fulfill contingency blood requirements to the ASWBPLs as required by DOD and the Army Blood Program Office.

(11) Be prepared to support with blood a national emergency anywhere in the world in a rapid, efficient, and adequate manner.

(12) Ensure the Army Blood Program supports DOD directed requirements.

(13) Encourage resource sharing with civilian blood programs after service requirements are met.

(14) Maintain an improving organizational performance (IOP) program which meets the requirements of the licensing and accrediting agencies (for example, FDA, AABB, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and CLIP). This includes the timely submission of error/accident reports as mandated by the FDA.

c. The following policies apply to the operation of the U.S. Army Blood Program.

(1) Operation of the program will be decentralized to the maximum extent possible, consistent with proper management and control. RMC blood program officers will report directly to the U.S. Army Blood Program Manager according to requirements of the FDA, thus demonstrating central control of the Army FDA license. RMC blood program officers will be appointed in writing by each RMC.

(2) The U.S. Army Blood Program will cooperate and integrate with similar programs of other uniformed services and/or Federal services while maintaining the best interests of the U.S. Army Blood Program.

(3) The U.S. Army Blood Program will cooperate and integrate with civilian blood programs at the regional/community level while maintaining the best interests of the U.S. Army Blood Program and ensuring consistency with DOD and DA policies.

(4) Blood resources that exceed the needs of a USAMEDCOM facility will be distributed in the following order of priority:

- (a) DOD ASWBPL quotas in peace and war.
- (b) Other USAMEDCOM facilities within the same RMC.
- (c) Other RMCs.
- (d) Other uniformed services facilities.
- (e) VA facilities.
- (f) Civilian blood banking activities for predetermined credits or fees.

(5) Army blood banks and transfusion services are not permitted to correspond directly with the FDA. All correspondence involving interaction with the FDA must be directed through the U.S. Army Blood Program Manager, USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

d. Policy addressing donors includes the following.

(1) Donors will not be provided in support of civilian blood programs without written authority of the USAMEDCOM commander so as not to adversely affect the Army's capability to provide for its own needs.

(2) Donor nourishments will be provided to assist in preventing minor donor reactions and for other medical reasons. Provision of these nourishments is an authorized Army expense from local funds. Nourishment in connection with blood collections accomplished by civilian organizations will be furnished by those organizations.

(3) All donations under the auspices of the unified/specified command blood programs will be voluntary in compliance with current FDA and AABB requirements. When standards are not identical, the more stringent will be followed.

(4) The voluntary blood donor is a person who meets patients' blood and component needs by donating without receiving compensation from the collecting facility, sponsor, or other external sources. Each soldier should be afforded the opportunity to donate on a voluntary basis.

(5) Commanders should support and encourage soldiers and civilian personnel to voluntarily donate. Although donors may not be forced or coerced to donate, reasonable incentives, inducements, and recognition may be offered to encourage donations. Pressure exerted by the chain of command to donate is not appropriate. A commander's policy of time off in order to donate blood is not considered payment or inducement. It is permissible to use lesser value incentives that would not motivate a potential donor to conceal detrimental medical background made available to all potential donors. Recognition items for donation milestones (for example, gallon donor awards, special donor recognition letters, etc.) are not considered inducements.

(6) Donors give blood with a full expectation that their living human tissue will be used for maintaining the life or improving the health of another human. In keeping this faith with the donor, extraordinary attention and effort must be used in avoiding waste (outdating) when at all possible. Managerial actions are a primary influence.

e. Army Blood Bank Centers have regional responsibility for providing inventory control and regional blood and blood product support as directed by the Army Blood Program Office.

f. Army collection centers will provide continuing training opportunities for technical services and skill development. They will also maintain blood collection equipment for mobilization and emergency requirements.

g. Each MTF which uses, or expects to use, blood for patient care will establish a sound business plan to support its blood and blood component needs. Each facility operating a blood collection facility will be FDA licensed. Contingency plans for mass casualty and mobilization must be in place.

h. When needs exceed local supplies, utilization of other uniformed services' blood programs is expected, with secondary alternatives to be exchange arrangements with local civilian blood banks. When blood or blood components cannot be obtained from the above sources, they may be purchased from licensed blood centers. Charges paid by the Army may not exceed the current local rate charged by civilian hospitals. Conversely, when local supplies exceed local requirements, excess stocks are to be made available to other DOD facilities. If the requirements of DOD facilities are met and an excess still exists, facilities are encouraged to offer excess blood and blood products to civilian institutions at the going rate to help defray manufacturing costs.

i. Recovered Plasma Exchange Program agreements with commercial firms are authorized and encouraged. This maximizes use of a valuable resource.

j. A records system will be developed and maintained to account for the manufacturing, acquisition, utilization, and disposition of all blood products to include recovered plasma assets in the medical blood programs as well as identifying all transient, acute, or chronic problems related to blood collection, transfusion, or other dispositions. Records retention will be according to FDA requirements.

k. Transfusion medicine programs related to the therapeutic use of blood and blood components, and the establishment and operation of transfusion services is beyond the scope of this chapter and will not be addressed.

5-4. Organization

a. Army blood banks and transfusion services will remain under the command and control of the appropriate MTF commander.

b. The U.S. Army Blood Program Manager, by virtue of being the Alternate Responsible Head for the DA FDA blood banking license, must have access and reporting authority to local QA coordinators. Therefore, some QA activities and requirements will be directed by the U.S. Army Blood Program Manager and reporting requirements may be mandated.

c. The QA coordinator will report to the management of the blood donor center or laboratory, as appropriate. This individual is part of the management team and should not be directly involved with the work he or she reviews. In smaller facilities, it may prove impossible to have a separate individual from the testing work force fulfill this requirement. If the blood bank supervisor, for instance, is designated as the blood bank QA coordinator, that supervisor cannot review his or her own work. The reporting authority for the local QA coordinator is to local management which has the authority to make changes and enforce requirements.

5-5. Individual blood group and type

a. All AD soldiers will have their blood group determined by both cell and serum grouping tests and their blood type determined by the use of Anti-Rho (D) serum.

b. The results of the grouping tests will be recorded using the international (Landsteiner) classifications of "A," "B," "O," and "AB." This blood typing will be noted on the SF 600 (Health Record-Chronological Record of Medical Care) overprint and filed in each soldier's HREC as a blood type for record. The results of the Rh typing test will be recorded as "POS" or "NEG." The individual blood group and type is used primarily for identification purposes, but can serve as a convenience in donor pre-screening when only selected bloods are needed.

c. Blood group and type determination will be made for all individuals processed through reception stations, training divisions, or similar organizations before transfer to other organizations. Blood group and type determinations for individuals not processed through such organizations ordinarily will be made at the initial Army installation or organization where the soldier reports for duty provided appropriate facilities are available.

5-6. Disposition of blood products

a. Surplus blood products.

(1) Blood is donated to the military in anticipation that it will be utilized to fulfill the need of someone in surgery who requires a transfusion of blood or blood products or other emergency purpose. This is a volunteer donation and, as such, there is a moral obligation to ensure the donated product is utilized as intended. Also, blood is in short supply within the United States and resource sharing is essential in order to meet the blood needs of the military and civilian health care systems.

(2) Blood and blood products have a short shelf life which ranges from 24 hours to 10 years depending on how the product was collected, preserved, and stored. Frequently, Army blood banks have product on hand or have the wrong ABO/Rh mix on hand in surplus of current requirements. In order to keep the trust of the donating public as well as to optimize the use of a product in short supply, sharing, exchanging, selling, or buying blood products is an important factor in doing business. The following guidelines are provided for local use.

(a) Excess blood should be made available on the open market.

(b) Blood should not be given away but it is reasonable to recover collection, processing, and storage costs when blood is provided to a civilian user. Reasonable fees may be recovered and should be based on cost or current market value.

(c) Blood or blood products licensed by the FDA may be exchanged or moved across State lines according to Federal regulations. In the District of Columbia all commerce within the District is considered Interstate. Intrastate movement of blood or blood products does not require the facility or product to be licensed.

(d) Any recovery of expenses may be returned to the operating funds of the local facility according to section 1095, title 10, United States Code (10 USC 1095).

b. Disposition of outdated blood products.

(1) General.

(a) Stored blood products have a short shelf life and on occasion disposal of outdated products is required. Outdated products may include recovered plasma, platelets, red blood cells, and many other products. These blood products frequently have value for the further manufacture into products used for treatment of medical conditions, diseases, or laboratory reagents.

(b) Since these outdated products frequently have residual value, it is recommended that such products be sold, traded, or exchanged in such a manner that the residual value may be recovered by the local MTF. This is authorized under 10 USC 1095.

(2) *Records.* Records tracing each blood product from collection to disposition must be strictly maintained allowing any inspector or auditor to establish a complete audit trail. FDA also requires strict manufacturing records maintenance and retention.

(3) *Labeling and shipment.*

(a) Products so disposed of will be labeled 'FOR USE IN MANUFACTURE OF NON-INJECTABLE PRODUCTS ONLY' according to FDA labeling guidelines. If the products are not labeled for non-injectable manufacture only, a short supply agreement is required.

(b) The label will meet current regulatory and accrediting requirements and contain all information required by law.

(c) For the purpose of uniformity and clarity in labeling, all labels used for this product must be approved by the U.S. Army Blood Program Manager.

5-7. Exchange or sale of outdated blood plasma

U.S. Army medical center (MEDCEN)/MEDDAC commanders will ensure that purchasing officers establish an exchange/sale agreement with a commercial processor of blood products whereby outdated blood products may be exchanged, sold, or otherwise capture the product's value. According to 10 USC 1095, any revenue generated by such an agreement may be retained at the local MTF.

Chapter 6 Dental Care

6-1. General

This chapter provides guidance for the delivery of oral health services within the Army Dental Care System (ADCS). AR 40-400 addresses dental care for AD personnel not assigned to an Army installation. The dental commander is responsible for delivery of effective and efficient dental care. Dental care provided will be consistent with accepted professional standards.

6-2. Authorization of care

All AD personnel are entitled to comprehensive dental care. Care to other-than-active-duty beneficiaries is authorized depending on space availability and according to statutory requirements.

6-3. Dental care priority

Dental commanders will determine how to employ available resources to improve oral health and dental readiness of supported personnel, taking into consideration the following factors:

a. Acuteness of the condition. Dental emergencies have the highest priority for care. The provision of all other dental care will be left to the professional judgment of the attending clinician consistent with the use of available resources as determined by the dental commander.

b. Impact on the Army's mission effectiveness. The major impact of oral disease on mission effectiveness occurs when military personnel develop acute oral conditions. The extent of this impact depends on the accessibility of dental care. Potential areas of concern are as follows:

(1) Army personnel being assigned or likely to be assigned to combat areas or deployed in support of operations other than war.

(2) Army personnel being assigned to isolated or remote areas.

c. Entitlement of care. The basis for degree of entitlement to care at a military dental treatment facility (DTF) is as stated in AR 40-400.

6-4. Dental examinations and screenings

a. Dental examinations. A dental examination must be performed by a dental officer or a privileged dentist (GS or contract). The examination will consist of a thorough evaluation of oral and adjacent tissues and a review of DA Form 5570 (Health Questionnaire for Dental Treatment).

(1) Personnel entering initial AD will have a panoramic x ray taken during initial dental processing as indicated.

(2) A dental examination is required each year for AD Army personnel.

(3) Dental examinations for persons evaluated under various medical fitness standards will be conducted under the provisions of AR 40-501. Appropriate diagnostic aids will be used as required.

(4) Any additional supplemental diagnostic procedures required for admission to the service academies will be accomplished.

(5) The findings of dental examinations will be recorded consistent with the instructions contained in TB MED 250.

b. Dental screenings. A screening of the oral cavity is utilized to detect gross pathology and to identify patients requiring treatment of potentially emergent conditions. Screening examinations may be performed by a trained technician under the supervision of a dentist.

6-5. Dental readiness classification

Recording dental classification in dental HRECs is useful in patient scheduling and dental care management. The primary measure of unit dental readiness is the dental readiness profile, defined as the percent of the unit in each class. Using summaries of the percent in each class to profile supported units, dental commanders can describe the oral health status to unit commanders. The classification will be entered in item 17 of SF 603 (Health Record-Dental) and SF 603A (Health Record-Dental-Continuation) under the column labeled 'class' following each patient visit. See AR 40-66 for instructions on the use of these forms. The oral health status of personnel shall be classified as follows:

- a. *Class 1.* Patients not requiring dental treatment or reevaluation within 12 months. Criteria are-
 - (1) No dental caries or defective restorations.
 - (2) Arrested caries for which treatment is not indicated.
 - (3) Healthy periodontium, no bleeding on probing; oral prophylaxis not indicated.
 - (4) Replacement of missing teeth not indicated.
 - (5) Unerupted, partially erupted, or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis and are not recommended for prophylactic removal.
- b. *Class 2.* Patients who have oral conditions that, if not treated or followed up, have the potential but are not expected to result in dental emergencies within 12 months. Criteria are-
 - (1) Treatment or follow up indicated for dental caries with minimal extension into dentin or minor defective restorations easily maintained by the patient where the condition does not cause definitive symptoms.
 - (2) Interim restorations or prostheses that can be maintained by the patient for a 12-month period. This includes teeth that have been restored with permanent restorative materials but for which protective coverage is indicated.
 - (3) Edentulous areas requiring prostheses but not on an immediate basis.
 - (4) Periodontal disease or periodontium exhibiting:
 - (a) Requirement for oral prophylaxis.
 - (b) Requirement for maintenance therapy; this includes stable or non-progressive mucogingival conditions requiring periodic evaluation.
 - (c) Non-specific gingivitis.
 - (d) Early or mild adult periodontitis.
 - (5) Unerupted, partially erupted, or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal.
 - (6) Active orthodontic treatment.
 - (7) Temporomandibular disorder patients in maintenance therapy.
- c. *Class 3.* Patients who have oral conditions that if not treated are expected to result in dental emergencies within 12 months. Patients should be placed in Class 3 when there are questions in determining classification between Class 2 and Class 3. Criteria are-
 - (1) Dental caries, tooth fractures, or defective restorations where the condition extends beyond the dentinoenamel junction and causes definitive symptoms; dental caries with moderate or advanced extension into dentin; and defective restorations not maintained by the patient.
 - (2) Interim restorations or prostheses that cannot be maintained for a 12-month period. This includes teeth that have been restored with permanent restorative materials but for which protective coverage is indicated.
 - (3) Periodontal diseases or periodontium exhibiting:
 - (a) Acute gingivitis or pericoronitis.
 - (b) Active moderate to advanced periodontitis.
 - (c) Periodontal abscess.
 - (d) Progressive mucogingival condition.
 - (e) Periodontal manifestations of systemic disease or hormonal disturbances.
 - (4) Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
 - (5) Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
 - (6) Chronic oral infections or other pathologic lesions including:
 - (a) Pulpal or periapical pathology requiring treatment.
 - (b) Lesions requiring biopsy or awaiting biopsy report.
 - (7) Emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or provide timely follow-up care (for example, drain or suture removal) until resolved.
 - (8) Temporomandibular disorders requiring active treatment.
- d. *Class 4.* Patients who require dental examinations. This includes patients who require annual or other required dental examinations and patients whose dental classifications are unknown.

6-6. Dental appointments

a. Whenever possible, DTFs will schedule appointments based upon the dental readiness status and the mission essential duties of the patient. The patient and/or unit commanders will be notified when scheduled appointments must be changed or canceled.

b. Unit commanders are responsible for the dental readiness of their personnel and for their personnel reporting for appointments promptly. The DTF will be notified as soon as possible when appointments must be canceled.

c. In coordination with responsible unit commanders, dental commanders will reduce broken and canceled appointments to minimum levels. Management techniques will be used to fill open appointments to the maximum extent possible.

d. Flexible appointment scheduling, determined by the type and extent of treatment planned, is essential for an efficient operation of a DTF.

e. Whenever possible, patients should be provided a written record of their scheduled appointments. DA Form 3982 (Medical and Dental Appointment) provides an effective format for this purpose.

f. Dental commanders will collect and analyze data on broken and canceled appointments. Time lost because of unfilled appointments will be analyzed and corrective actions taken as necessary.

6-7. Audit system

Dental commanders will implement a functional audit system. This system will ensure that electronically generated dental workload reports are correct and the daily treatment entry on the SF 603/603A accurately represents the care provided. A standard of care evaluation of the treatment provided will be part of the audit system.

6-8. Preventive dentistry

a. The prevalence of oral disease and injury among Army beneficiaries is so great that cure and restoration of these conditions exceeds the capability of the ADCS. The costs associated with providing direct care or dental insurance programs can be reduced by the avoidance of preventable diseases and injuries. To reduce the prevalence of oral disease and injury, the ADCS will conduct a preventive dentistry program with three components: the Oral Health Fitness Program, the Clinical Preventive Dentistry Program, and the Community Preventive Dentistry Program. The details of these programs are found in AR 40-35.

b. The community director of dental services (DDS) will conduct preventive dentistry programs for the military population within their area of responsibility. The highest priority will be given to services that improve the dental readiness of soldiers in support of military operations.

c. All dental treatment plans will include measures to promote oral health and prevent dental disease and injury.

d. General health promotion and disease prevention (for example, hypertension screening, tobacco intervention, and nutrition education) will be integrated into dental programs. The DDS will also seek ways to integrate oral health promotion and disease prevention into AMEDD and community programs (for example, nutrition, neonatal education, community health visits, school programs, physical examinations, and outpatient and TMC visits).

e. Installation water fluoride adjustment is important for the maintenance of adult dental health as well as child dental health. The DDS should establish procedures to assist in periodic fluoride surveillance and educate the community on requirements for safe and effective fluoride measures.

Chapter 7 Medical Libraries

7-1. Purpose

This chapter prescribes policies, standards and procedures, and provides guidance for the AMEDD Medical Library and Information Network (AMEDD MEDLI-NET).

7-2. Applicability

This chapter applies to all libraries, library systems, information centers, and library programs within the AMEDD. Specifically included are the USAMEDCOM libraries, U.S. Army Medical Research and Materiel Command (USAMRMC) libraries and information centers, Stimson Library at the AMEDD Center and School (AMEDD C&S), and the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) library. Specifically excluded are the Armed Forces Medical Library (AR 10-64/OPNAVINST 6700.2/AFR 160-29/MCO 5420.18A), patients' libraries under monitorship of the USAMEDCOM, and other general library collections and services offering diverse self-developmental reading.

7-3. Objectives

The objectives of the AMEDD MEDLI-NET are to-

- a. Organize all AMEDD libraries and information centers into an integrated library and information network providing the level and degree of information services required by all elements of the AMEDD.
- b. Make the latest library and information science techniques and network technologies available to AMEDD libraries and information centers and their clientele through the AMEDD MEDLI-NET and other electronic gateways.
- c. Ensure the highest quality library and information services are provided to all echelons of the AMEDD.
- d. Promote electronic connectivity with local, State, regional, Federal, and non-Governmental library networks.

7-4. Responsibilities

- a. The Assistant Chief of Staff for Health Policy and Services, USAMEDCOM, is the executive agent responsible for developing policies and procedures for the AMEDD MEDLI-NET.
- b. USAMEDCOM, USAMRMC, AMEDD C&S, and USACHPPM commanders at all levels will ensure compliance with this regulation.
- c. The USAMEDCOM Library Program Director (MACOM Librarian) will-
 - (1) Advise the Assistant Chief of Staff for Health Policy and Services, on matters concerning the command's library program.
 - (2) Serve as Deputy Career Program Manager for medical librarians in the Army Civilian Librarian Career Program and represent the command on its planning board and screening panel.
 - (3) Serve as principal spokesperson for the USAMEDCOM on medical library matters.
 - (4) Serve as the commander's representative to Federal, non-Federal, civilian, and Army library groups/committees.
 - (5) Assess the library program and individual library activities through consultation and on-site visits to CONUS and overseas USAMEDCOM medical library facilities.
 - (6) Review, analyze, and consolidate the library management annual reports submitted on DA Form 7397-R (U.S. Army Medical Command Library Annual Report FY__). (See para 7-8.)
- d. The librarian/technical information specialist will be responsible for all aspects of the library/information program to include at least the following:
 - (1) Developing programs and services in support of the AMEDD that are customer-oriented, demand-driven, and knowledge-based.
 - (2) Applying rapidly changing information technologies in the acquisition, storage, management, and dissemination of knowledge-based information.
 - (3) Developing an effective marketing plan to promote its collection, products, and services.
 - (4) Evaluating the performance and continuous improvement of AMEDD libraries and information centers through the use of formal and informal needs assessment surveys.
 - (5) Developing local policies and regulations governing the use of an AMEDD library or information center with approval by the commander, or his or her designee.
 - (6) Employing the use of quality filtering techniques in retrieving information.

7-5. Policy

- a. Medical libraries will be established at all MEDCENs and MEDDACs subject to the approval of the Commander, USAMEDCOM (MCHO-CL), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.
- b. Libraries established at the AMEDD C&S, USACHPPM, and USAMRMC are subject to approval by the responsible major subordinate commander.
- c. Medical libraries will comply with the JCAHO standards for knowledge-based information.
- d. MEDCEN and MEDDAC medical libraries will use the Medical Library Association's (MLA's) hospital library standards to develop and evaluate services and/or policies.
- e. At graduate medical education program sites, the level of services and on-site accessibility to the library will comply with the accrediting requirements of the Accreditation Council for Graduate Medical Education and the residency review committees for the various specialties.
- f. A medical library committee representing a cross section of the professional staff will be established to serve in an advisory capacity to the medical librarian.
- g. All AMEDD libraries and information centers will participate in the AMEDD MEDLI-NET.
- h. AMEDD libraries and information centers will share their collective resources through the following services: interlibrary loan/document delivery; bibliographic access to journals, monographs, technical reports, and audiovisual information; duplicate/excess journals exchange; and cooperative technical processing.
- i. AMEDD libraries and information centers will use commercial search services and networks to ensure AMEDD staffs have access to the required multimedia bibliographic and online services.
- j. Libraries will provide reference and bibliographic services to all authorized users and to personnel who are on temporary duty (TDY) to the facility.
- k. The library staff will conduct a continuous program of orientation and instruction for the AMEDD staff in the use of the library and managing knowledge-based information.

- l.* The library's circulation system records will ensure the proper lending, safeguarding, and return of library materials. There will be an organized plan for the systematic follow-up and return of overdue library materials.
- m.* Indefinite loan collections should be kept to a minimum and should include only items used daily.
- n.* Library personnel will ensure that interlibrary loan policies-
- (1) Conform to the interlibrary loan codes of the National Library of Medicine (NLM), the American Library Association, and the guidelines of the Commission on New Technological Uses of Copyrighted Works.
 - (2) Promote the use of the most expeditious and cost-effective interlibrary loan/document delivery services for obtaining the loan or photocopy of materials required by staff in connection with their official duties.
 - (3) Address payment for interlibrary loans/document delivery by establishing accounts with the Federal Library and Information Network and non-Federal institutions.
 - (4) Use the following guidelines for mailing library materials.
 - (a) AR 25-51 permits the use of registered, first-class mail for books and other library materials that are one-of-a-kind, out-of-print, irreplaceable, or exceed \$200 in value.
 - (b) Numbered, insured mail will be used to return borrowed library and similar items when required by non-Government lenders.
 - (c) Third class or fourth class mail, depending on the weight of materials, will be used to ship library materials which are not specified in the above categories.
 - (d) Overnight delivery is authorized when necessary to meet mission requirements.
 - (5) Designate the use of DOCLINE, the NLM's National Network of Libraries automated interlibrary loan and referral system.
 - (6) Use the Union List of Serials Report for SERHOLD^(tm) as the mechanism for updating their journal collection holdings. This report will be made annually and submitted via the AMEDD MEDLI-NET World Wide Web home page. The use of this form is self explanatory.
 - (7) Comply with the provisions of the Copyright Law, P.L. 94-553. On-demand systematic copy services staffed by Government employees are not authorized; such a service is in violation of the copyright law. Libraries may make photocopies for interlibrary loan within the guidelines of the law.
 - o.* When feasible, technical services functions of acquisitions, cataloging, and shelf-ready processing may be consolidated for AMEDD libraries collocated on the same installation.
 - p.* The NLM Classification Scheme and the NLM Subject Headings will be used for cataloging and classifying books. Library of Congress (LC) classification and subject headings will be used for non medical titles.
 - q.* Libraries without online access to the Online Computer Library Center (OCLC) will order cards from commercial sources that use the standard Machine-Readable Cataloging format and provide cataloging from NLM and LC. Original cataloging will not be done locally unless OCLC access is available on site.
 - r.* If local policy dictates, audiovisual/visual information units will be cataloged and incorporated into the library's collection.
 - s.* A local policy for binding will be formulated. In clinical libraries, priority will be given to those journals indexed in standard indexing services, such as INDEX MEDICUS, PSYCHOLOGICAL ABSTRACTS, etc.
 - t.* AMEDD libraries and information centers will develop a local policy for withdrawing outdated or unused materials from the library collection. This policy will identify any mission-related requirements impacting the retention of these materials.
 - u.* Membership in the MLA is recommended for all AMEDD libraries.
 - v.* Each medical librarian will obtain copies of the U.S. edition of the NATO Handbook of Emergency War Surgery (CMH Pub 83-3) in sufficient quantity to allow issuance by commanders to each medical, dental, and veterinary corps officer upon first coming on AD. These handbooks become the personal property of the officer and are not accountable.
 - w.* The medical library committee may advise on the selection of those materials that will be housed in the library or exist on the library inventory. The librarian/technical information specialist will serve as reviewer for the acquisition of library materials in various formats for the organization. The librarian/information specialist is not authorized to make credit card purchases of materials not housed in the library or existing on the library inventory.
 - x.* AMEDD libraries and information centers should be staffed during the facility's regular duty hours. After hours, key-card access is authorized in compliance with the JCAHO standards and those of other accrediting agencies.
 - y.* Physical facilities will be readily accessible to the staff and should be large enough to house the collection and have space for services provided, without encroaching on reading and study areas. Reading and study areas will be reserved for library users.
 - z.* AMEDD libraries and information centers should have the appropriate equipment to accomplish the mission of the facility the most cost effectively. Photocopiers should be maintained for all AMEDD libraries and information centers to ensure maximum use of the collection and to minimize losses of collection materials.

7-6. Personnel

a. AMEDD libraries and information centers will be staffed by individuals in the following series according to the provisions of the Civil Service Handbook X-118, Qualification Standards Handbook: GS-1410, Professional Librarian; GS-1411, Library Technician; or GS-1412, Technical Information Specialist. Libraries without an individual in one of these series should request periodic consultations from the command medical librarian or their regional MEDCEN.

b. AMEDD libraries and information centers staffed by a professional librarian in the GS-1410 series will place the librarian on orders as the accountable property officer for the library according to AR 735-17.

c. Clinical libraries shall, whenever feasible, be directed by a qualified medical librarian holding a graduate degree in library science from an American Library Association accredited library school. Clinical libraries may also be directed by a library administrator with equivalent education or experience.

d. All library activities will have adequate clerical support for the performance of routine medical library functions.

e. Mission essential training and continuing education courses are required for AMEDD library staff to develop skills and specializations required by the continually evolving disciplines of library and information science. Certification by the MLA is desirable and recommended. The MLA credentialing program, the Academy of Health Information Professionals, demonstrates initiative in completing an approved educational program for professional development.

f. AMEDD library and information center staffs are encouraged to join and participate in local consortia and additional professional library organizations.

g. At clinical libraries adequately staffed by individuals in the GS-1410 or GS-1412 series, specialized services, such as a Clinical Medical Librarianship program or Literature Attached to Charts program may be established, as required.

7-7. Collection development

a. Collections will support the patient care, health care administration, education, training, readiness, and research needs of the organization.

b. Regional cooperative collection development policies for AMEDD libraries and information centers will be developed to eliminate unnecessary duplication.

c. Development of the AMEDD library and information center collection will be based on the collection development guidelines determined by the library staff. Collections should include material in the following categories as determined by the librarian/technical information specialist and recommended by the medical library committee, as appropriate:

- (1) Journal subscriptions.
- (2) Monographs and textbooks.
- (3) Reference materials.
- (4) Reprints of staff and other source publications.
- (5) Patient education/consumer health.

d. AMEDD libraries and information centers will, where feasible, retain first copies of all texts in the library's collection and will not sign them out on indefinite loan. Second and successive copies may be purchased for indefinite loan libraries pending the review by the librarian and the availability of funds.

e. Increased demands for access to electronic information in the collection requires the availability of hardware and software to support customer needs. As a minimum standard, AMEDD libraries should have the technology to use CD-ROMs and access automated services, such as online bibliographic and cataloging services, the AMEDD MEDLI-NET, the Internet, and other electronic information sources.

7-8. Management reporting (RCS MED-402)

Each AMEDD library and information center will submit DA Form 7397-R. The report summarizing data from the fiscal year (FY) will be submitted by 31 October to the Commander, USAMEDCOM (MCHO-CL), 2050 Worth Road, Fort Sam Houston, TX 78234-6010. (DA Form 7397-R will be locally reproduced on 8 1/2- by 11-inch paper unless available electronically. A copy for reproduction purposes is located at the back of this regulation; app C contains instructions for the use of this form.)

7-9. Accountability

Policies addressing accountability and inventory will be according to AR 735-17.

7-10. Procurement

AMEDD libraries and information centers will utilize the most cost effective and responsive means of acquiring materials in support of the facility's mission.

Chapter 8

Nutrition Care Management

8-1. Purpose and scope

This chapter prescribes regulatory policies for the operation of the Nutrition Care Division (NCD) in fixed MTFs. For operational policies and procedures for food service in non-fixed MTFs, refer to AR 30-1, AR 30-21, and FM 8-505.

8-2. Mission

The mission of the NCD is to provide-

- a. Comprehensive nutritional care.
- b. Safe, wholesome foods including modified diets, as required, to patients and personnel authorized to subsist in the MTF.
- c. Dietary/nutritional assessment of authorized beneficiaries.
- d. Medical nutrition therapy for authorized beneficiaries.
- e. Nutrition education and health promotion.
- f. An American Dietetic Association (ADA) accredited Dietetic Internship program.
- g. Consultation and support to commanders on the nutritional aspect of Army programs, field training exercises, and joint training exercises.
- h. Applied research.

8-3. Organization and functions

The organization and functions of the NCD will be as prescribed by the medical command having jurisdiction over the MTF.

8-4. Responsibilities

- a. MTF commanders will-
 - (1) Ensure the provision of nutritionally adequate meals within the value of the Basic Daily Food Allowance (BDFFA).
 - (2) Ensure that the hospital meal charge policy is implemented according to DOD 7000.14-R, Volume 12, chapter 19 and DA guidance. However, when changing meal charge policies, servicing Civilian Personnel Offices will be consulted regarding any bargaining obligations to recognized unions under the Labor Relation Statute.
 - (3) Ensure mechanisms are in place that guarantee the ongoing competence of all categories of nutrition care personnel, to include use of clinical privileges according to AR 40-48 and AR 40-68 as appropriate.
 - (4) Ensure proper utilization of dietitians and hospital food service specialists according to AR 40-1 and DA Pam 611-21.
 - (5) Ensure that adequate internal controls exist according to AR 11-2 for procurement of safe and wholesome subsistence and prevention of waste, fraud, and abuse of subsistence and supplies.
- b. The Chief, NCD, will—
 - (1) Be responsible to the commander for operating all NCD activities.
 - (2) Maintain standards established by TB MED 530, JCAHO standards, and local hospital regulations.
 - (3) Provide the vision, leadership, and motivation to guide the division in accomplishing its mission.
 - (4) Establish a locally approved IOP program according to AR 40-68 and the JCAHO.
 - (5) Ensure 65C and 91M Professional Filler System positions are filled and trained.
- c. The noncommissioned officer in charge will-
 - (1) Develop and enforce standard operating procedures for cashiers and cash accountability to the medical services accountable officer (MSAO).
 - (2) Provide overall supervision and training of all enlisted personnel including a Medical Proficiency Training (MPT) Program with the local MTOE unit and training with RC personnel.

8-5. Persons authorized to eat in the MTF NCD

- a. The primary purpose of the NCD is to feed inpatients and enlisted personnel entitled to subsistence-in-kind (SIK). The MTF commander may authorize other personnel access on a regular or occasional basis.
- b. Meal rates charged to authorized personnel using the MTF dining facility are based on guidance contained in DOD 7000.14-R, Volume 12, chapter 19 and DA guidance.
- c. The MTF must establish a method of identifying categories of authorized personnel that is consistent with MSAO requirements.

8-6. Cash collections

- a. When used to collect cash reimbursements for meals, the cash register system will-

- (1) Provide paper receipt to each patron that indicates the diner category and the total value of the transaction.
 - (2) Maintain-electronically or on paper tape-a retrievable detailed record of all entries into the cash register.
 - (3) Provide access to the cash drawer when power is not available.
- b.* Manual cash collections of meal reimbursements will use DA Form 3032 (Signature Headcount Sheet) for SIK personnel and DA Form 3801 (Guest Log for Meals) for cash collections.
 - c.* To show accountability and collections for the 24-hour period, DA Form 3158 (Statement of MSA Dining Hall Cash Receipts and Meals Served) or an electronically generated form may be used.
 - d.* Change funds to support cash collections are established and maintained by the NCD staff.

8-7. Personnel management

- a.* An established training and orientation program is essential for optimal work performance and staff competence. Training, at a minimum, will include topics identified by the JCAHO and DOD (for example, ethics training). Registered dietitians and registered dietetic technicians will earn sufficient continuing education credits to maintain registration.
- b.* The NCD training program and MPT Program for hospital food service specialists (91M) will emphasize career development and MOS proficiency. Training programs to support RC units are tailored to individual needs and time constraints. Overall training must address common soldier tasks for table(s) of distribution and allowances (TDA) and table of organization and equipment (TOE) MTFs.

8-8. Standard hospital diets

The most current American Dietetics Association (ADA) manual is the only authorized diet manual for use in Army MTFs.

8-9. Clinical dietetics management

- a.* The patient's medical nutrition therapy will be planned and will include collaborative nutritional screening, assessment, and monitoring to enhance recovery, promote optimum nutritional status, decrease health risks, and eliminate or promote effectiveness of drug therapy. Dietitians, dietetic technicians, diet aides, and hospital food service specialists (91M) perform the professional and supportive duties required to ensure the prescribed diet is served.
- b.* Standard diet orders are found in the most current ADA manual. The physician or other individual with appropriate clinical privileges will order the diet before any food or other nutrient is administered to the patient. The diet orders will be transmitted to the Clinical Dietetics Branch.
- c.* All patients admitted to the MTF will be screened. The criteria for screening will be locally developed and implemented. For patients at nutritional risk, a treatment plan will be developed and periodically updated. Patients not at nutritional risk will be rescreened at designated intervals.
- d.* The mechanism for identifying patients who need dietary counseling will be locally developed and implemented. Patients will be instructed on potential drug-food interactions and provided counseling on nutrition and modified diets. When a patient is discharged to another health care organization, a description or copy of the diet information is forwarded to the receiving facility.
- e.* Nutritional care will be documented in the patient's medical record. This includes pertinent subjective dietary history information; objective medical, clinical, anthropometric, and diet order information; the assessment of the patient's nutritional status; recommendations and/or plans for implementation of nutritional intervention; and quantifiable dietary goals. Inpatient nutritional care documentation is recorded on the SF 509 (Medical Record-Progress Notes), and outpatient care is documented on the SF 600 or an authorized automated equivalent. Locally approved overprints on DA Form 4700 (Medical Record-Supplemental Medical Data) may also be used according to AR 40-66.
- f.* The SF 513 (Medical Record-Consultation Sheet) is used to document response to consultations. Dietetic consultations will be reported to the requesting practitioner by entry on SF 513 or an automated equivalent. A dietetic consultation is not required for nutrition assessment.
- g.* Registered dietitians with advanced training in clinical nutrition and nutritional assessment will be members of the nutrition support team.
- h.* Procedures for service of food to patients will be determined by organizational policy and will be coordinated with chiefs of clinical dietetics and nursing services. Tray service will be limited to patient feeding. Duty personnel are prohibited from eating food intended for patients. Exception to policy may be made to provide tray service for security personnel while guarding a patient when appropriate payment or signature is obtained.
 - (1) Each tray served will be identified with the patient's name, room number, and diet prescription.
 - (2) Isolation procedures will be established within each MTF and will be approved in writing by the local MTF infection control committee.
 - (3) DA Form 2927 (Hospital Food Service-Telephone Diet Order) or equivalent documentation will be maintained by Clinical Dietetics Branch to ensure accurate transmission of diet order and tray delivery information.
 - (4) The NCD will deliver nourishments and supplemental fluids to the wards at locally established times. Nursing personnel are normally responsible for nourishment receipt and distribution.

i. Nutrition education will be provided in support of health promotion and wellness programs, the Army Body Composition Program (AR 600-9), formerly the Army Weight Control Program, Child Development Services, and the military community to the extent resources permit.

j. The Chief, Clinical Dietetics Branch, is responsible for recommending medical nutritional products for inclusion in the MTF formulary. A local policy with written approval by the Pharmacy and Therapeutics (P&T) Committee shall direct the procedures involved with dispensing medical nutritional products to patients.

k. Clinical dietitians will participate in locally established peer review committees that use the patient's medical record as the basis for determining the quality and appropriateness of nutritional care.

8-10. The MTF menu

The MTF menu will be planned to provide nutritionally adequate meals within established monetary limitations. All menus for regular and modified diets will be preplanned, approved, and signed by a registered dietitian. The Chief, NCD will incorporate the provisions of AR 40-25/NAVMEDCOMINST 10110.1/AFR 160-95 into the MTF menu.

8-11. Subsistence and supply management

Efficient operation of the NCD is largely dependent upon adequate control over purchase, inspection, receipt, storage, and issue of food items and supplies. Losses and discrepancies will be immediately investigated and the Chief, NCD will initiate appropriate follow-up action. Subsistence procured with appropriated funds will not be used to support meetings, conferences, staff calls, boards, VIP visits, or social functions unless appropriate reimbursement is provided. Procedures for support of social functions are outlined in AR 215-1.

a. *Food requisitions.* All subsistence items for a fixed MTF, including special patient feeding items, will be supplied by the Prime Vendor (according to Defense Personnel Support Center policies), Troop Issue Support Activity (TISA) (according to AR 30-18), and/or the installation commissary (according to AR 30-19).

b. *Receipt of food.*

(1) The Prime Vendor Contractor/TISA/commissary store issues subsistence only to persons with proper identification authorized by the Chief, NCD. For appropriate control, the individual authorized to receive subsistence will not be the same person authorized to order it. The receipt copy of the food requisition or vendor invoice serves as the basis for food receipt entries into the Nutrition Management Information System (NMIS).

(2) All food items not required for immediate use will be stored in a temperature controlled, secure food supply storeroom. Secure refrigerated storerooms will be used. All non-food supplies will be stored in secure non-food storage areas and designated as non-food storage.

c. *Physical inventory.* All subsistence items on hand will be physically counted on the last working day of each month. The Chief, NCD will appoint personnel to assist in the physical inventory. Two teams will be used. The reconciliation of counts between the teams should not take place until the entire inventory has been completed. The MTF commander or designee will appoint a disinterested officer or noncommissioned officer (staff sergeant and above) to at least one inventory team to verify procedures at mid-FY and at end-FY. Inventory value is determined by multiplying the number of issue units on hand by the most recent price of the item received (current costing).

(1) *Inventory control.* As a guideline, the value of the food inventory should normally not exceed 10 percent of the previous FY authorized monetary value allowed for subsistence. Differences greater than 0.5 percent of the total value for all items under perpetual inventory should be investigated, explained, and corrected.

(2) *Perpetual inventory.* NMIS provides a perpetual inventory on all subsistence items. A 10 percent sample of total inventory line items should be selected on a monthly basis for review.

d. *Operational rations.* Operational rations required to support medical field training will not be charged against the MTF subsistence account. DFAS-IN Manual 37-100-FY permits the MTF budget officer to charge field rations for both officer and enlisted personnel against the Military Personnel Appropriation Project 1321-0. MTF cash collection and signature headcount sheets (DA Form 3032 and DA Form 3801) will not be used for field training exercises. Ration accountability will be according to AR 30-21 for all field training that incorporates overnight field billeting. The accounts of the field feeding operation will not be combined with that of the fixed facility. Accountability is the responsibility of the commander conducting the exercise.

8-12. Food management

a. The Chief, NCD will establish control measures to assure high quality food products according to standardized recipes. The Chief, NCD will ensure compliance with TB MED 530 and appropriate JCAHO standards.

b. Box meals may be offered to those personnel authorized to subsist in the NCD. The standard meal rate is applicable for box meals, carry out meals, and meals consumed in the dining facility. If economically feasible, a night meal may be served to support night-duty personnel and patients admitted after the scheduled dinner meal.

8-13. A La Carte Meal Service

a. MTFs are authorized to use the A La Carte Meal Service in lieu of the Traditional Meal Service. (The Traditional

Meal Pricing System charges a fixed price for a complete meal while the A La Carte Meal Pricing System charges for individual menu items.) The A La Carte Meal Service will only be used when the following are present:

- (1) NMIS for recipe costing.
- (2) Physical layout which controls access to the serving line and places the cash register at the end of the food serving area.

- (3) Point-of-sale cash register appropriate for the A La Carte Meal Pricing System.

b. Calculations for workload and authorized monetary value allowed for subsistence for a la carte operations are as follows.

- (1) Patient and SIK meal days are computed by multiplying meals by the appropriate conversion factor in table 8-1.
- (2) Each dining facility patron counts as a 'meal,' regardless of the amount of food consumed. Meals are converted to meal days by multiplying by the appropriate conversion factor in table 8-1.

- (3) To determine the authorized monetary value allowed for subsistence (earnings), patient and SIK meal days are multiplied by the appropriate BDFA. To determine earnings from cash patrons, subtract the operating costs from the total cash collected.

c. Commanders may authorize use of fixed meal prices for special occasions such as Thanksgiving or Christmas. The price charged may be either the DOD established holiday rate or a rate established by a weighted average of individual meal component prices. Additional funds are not authorized if the DOD rate is used and it is less than the cost of the food.

8-14. Ration accounting

a. The Chief, NCD; troop issue subsistence officer; or commissary officer at each CONUS installation and the agency designated by major overseas commanders will compute the value of the MTF BDFA according to AR 30-18 and will provide it to the MTF commander prior to the beginning of each accounting period. The Chief, NCD will maintain accurate records of meals served and meal days (rations) served to provide cost and earnings data for management and reporting purposes.

b. The Daily Facility Summary (generated by the NMIS) will be completed for each dining facility.

c. The Monthly Monetary Record (generated by the NMIS) is used to manage and control food costs for an a la carte operation. Weighted meal days and earned income, by category and total, are reported along with subsistence purchases and issue information. When closing inventory is entered, account status and other management ratios are displayed.

d. For the traditional Thanksgiving and Christmas meals, an increased holiday allowance of 25 percent is authorized for holiday meals only.

8-15. Food cost management

a. The Chief, NCD is responsible for maintaining proper security measures and adequate control over supplies. The Chief, NCD is responsible for maintaining the total value of subsistence within plus or minus 1 percent of the total authorized monetary value allowed for subsistence for the FY.

b. When the authorized monetary value allowed for subsistence is insufficient to provide adequate subsistence, commanders may request authority through their RMC to Commander, USAMEDCOM (MCRM), 2050 Worth Road, Fort Sam Houston, TX, 78234-6111, to use a higher MTF subsistence allowance rate. Normally, requests will be submitted only when less than 100 meal days per day are being served. Requests will include the following:

- (1) Average number of meal days served per day for each of the 3 preceding calendar months and the authorized MTF BDFA for each of the 3 months.

- (2) Forecast of the average number of meal days to be served per day for the current month and each of the succeeding 3 months and the MTF BDFA for the current month.

- (3) Statement of the conditions necessitating an increased allowance.

- (4) Recommendation as to the amount of increased allowance needed, expressed as a percentage (for example, a 10 percent increase) over the MTF BDFA.

- (5) Ability of the MTF to finance the increased allowance.

- (6) A statement indicating that costs will not be increased as a result of providing items or services to non-patient personnel when such items or services are not provided in installation troop feeding facilities. (The intent is that non-patient personnel subsisting in the NCD be provided subsistence at a comparable level with troop feeding facilities.)

8-16. The NCD activities report

The NCD activities report will be submitted to the appropriate regional NCD chief. Regional personnel will consolidate the report and send to Commander, USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, by the 20th calendar day following the end of the reporting month; 18th Medical Command will submit the report directly to the USAMEDCOM at the above address.

8-17. NCD contracts

The NCD contract officers representative will be responsible for operating the food production service according to all provisions of this regulation. The following specific guidance is provided.

a. All food production forms shall be retained for a period of time specified in the contract. In the absence of a contractual provision requiring a specified period of time to retain food production forms, such forms shall be retained in accordance with AR 40-66.

b. For purpose of the monthly physical inventory, Government food service QA specialists are considered disinterested participants.

c. Contract provisions, when more stringent, shall prevail.

d. Contractor personnel will not be included in the personnel strength totals on the NCD Activities Report.

8-18. Termination of MTF nutrition care operations

a. During the inactivation period of an MTF, the reduction of food inventory and food procurement will be commensurate with diminishing feeding requirements. Surplus items will be turned into the TISA or the installation commissary officer for reimbursement to Army medical activities funds. To the extent practicable, economical utilization of subsistence supplies on hand will take precedence over additional food procurement.

b. When NCD operations terminate, subsistence items (including special patient feeding items), expendable supplies, and equipment items which are not returnable for reimbursement will be made available to another Army MTF (usually the nearest facility) as directed by the RMC concerned. Transfer will be according to AR 710-2.

8-19. Other Food Service Support

a. The A La Carte Meal Pricing System is a customer oriented system having the capability of computing the full reimbursement value of food items provided for purposes other than meals, for example, official functions. While this capability makes Other Food Service Support possible, it is limited to those MTFs that have the A La Carte Meal Pricing System and to appropriate hospital or military functions that can be accomplished without compromising patient and staff feeding. Provision of this support is not intended to become a significant part of the NCD workload.

b. NCD resources are provided to support the primary mission of feeding patients and authorized patrons. Other Food Service Support should not be considered an additional mission, but rather a value added enhancement. If the primary mission changes, the provision of Other Food Service Support may be curtailed or eliminated if additional resources are not made available.

c. MTF commanders will establish local written policies to clearly define implementation procedures for Other Food Service Support. Policies will include measures to prevent misuse (actual or perceived) of Government facilities, equipment, food and personnel, and to provide specific guidance on internal control measures, reimbursement and accountability of funds, food, and supplies.

d. Additional information and specific guidance for implementation of the A La Carte Meal Service is available from the USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

Table 8-1
Meal conversion factors (weights)

Meal	Factor
Breakfast	0.2
Lunch	0.4
Dinner	0.4
Brunch	0.45
Night meal	.20 or .40 (See note 1.)
Holiday	.65 (See note 2.)

Notes:

¹ Depends on whether breakfast or dinner menu is served.

² .40 lunch plus .25 percent of BDFA.

Chapter 9

The Army Organ Transplant and Organ/Tissue Donation Programs

9-1. The Army Organ Transplant Program

a. Objective. The Army Organ Transplant Program is established to perform organ transplantation in DOD MTFs for patients who have statutory entitlement to care or are covered by VA/DOD health care resource sharing agreements (38 USC 8111) and require this service.

b. Policy.

(1) Organ procurement and distribution will utilize the established system of Organ Procurement Organizations (OPOs) and listing program of the National Organ Procurement and Transplantation Network (OPTN) except as noted in paragraph (2) below. It is the responsibility of the MTF to notify the local OPO about potential organ and tissue donors. Consent should be the responsibility of the OPO.

(2) The Army Organ Transplant Program may establish voluntary MOAs with various OPOs and MTFs to implement the Military Organ Donor Program which allows use of organs procured from DOD beneficiaries preferentially in DOD recipients.

(3) Cadaveric organ and tissue donation should be promoted in all Army MTFs. The Chief, Army Organ Transplant Program, will collaborate as needed with MTF commanders to ensure education of their personnel regarding organ donation but use of the local OPO should be the standard for this function. The Army Organ Transplant Program is also responsible for providing education to personnel and their family members Army wide regarding their prerogatives in post mortem organ and tissue donation.

(4) Living-related and living-unrelated organ donors may be utilized from informed, voluntary adults who are competent, emotionally stable, and in good health. Evaluation of potential donors will be undertaken initially by qualified, organ-specific specialists outside the Program to assure objective evaluation. Informed consent will be obtained and the donor informed of potential immediate complications and his or her long-term outlook.

(5) The Army Organ Transplant Program may provide transplant services for all organs for which the surgical team meets established training and experience criteria as established by the National OPTN, the transplant community, and as approved by the DASG-HS-AP, 5109 Leesburg Pike, Falls Church, VA 22041-3258.

(6) Patients may be accepted to the Program from military or civilian referrals.

c. Special consideration affecting volunteer donors.

(1) Living donors who are not DOD beneficiaries may be used as donors for DOD recipients subject to approval of the Secretary of the Army and receipt of Designee status. A statement of good health and basic laboratories will be obtained initially by the donor's civilian physician before consideration. The Transplant Program will perform the pre-transplant evaluation and provide operative and post-operative care for a period determined by the Secretary of the Army. Requests will be made in writing to the DASG-HS-AP, 5109 Leesburg Pike, Falls Church, VA 22041-3258.

(2) The Army assumes no liability in the case of a non-DOD beneficiary donor whose donation results in mortality. Exceptions to this position will apply only under circumstances giving rise to a claim or action under the Federal Tort Claims Act.

d. AD members as donors.

(1) There is no objection to an AD Army member executing a declaration of intent to donate organs or tissues after death under the Uniform Anatomical Gift Act.

(2) AD members may serve as living-related or living-unrelated organ donors in the absence of better-matched volunteer donors.

(3) The AD member must be counseled in writing by the immediate commander with a follow-on counseling by a medical officer. The counseling sessions must ensure that the AD member understands before donation of an organ that his or her qualification for continued service will be contingent upon favorable medical evaluation results following organ donation.

(4) Any disability or mortality resulting from organ donation made by an AD Army member in accordance with this chapter will be considered "in line of duty." Otherwise, line-of-duty determinations will be made according to applicable provisions of AR 600-8-1. (Apply the 18 September 1986 version of this regulation until publication of AR 600-8-4, Line of Duty Investigations.)

(5) Prior approval from OTSG is required when living organ donation by an AD Army member is to be performed in a transplant facility other than the Army Organ Transplant Service, Walter Reed Army Medical Center. Request for such approval should be submitted through the individual's unit commander to the local MTF Patient Administration Division to be forwarded to OTSG (DASG-HS-AP), 5109 Leesburg Pike, Falls Church, VA 22041-3258. Circumstances requiring more immediate response may be approved telephonically with OTSG. Requests for live organ donation to be performed in the Army Organ Transplant Service may be sent directly to the Chief, Organ Transplant Service, Walter Reed Army Medical Center, Washington, DC 20307-5001. All requests to serve as an AD live organ donor must contain the following information:

(a) Name, grade, SSN, and unit of prospective donor.

(b) Recipient's name and relationship to donor.

- (c) Recipient's diagnosis and prognosis.
 - (d) Name of recipient's physician and place of transplant.
 - (e) Statement acknowledging prospective donor's understanding of required counseling by a medical officer.
 - (f) Acknowledgment that the Army is not responsible for any costs associated with a transplant performed in a civilian institution except when the recipient is a DOD beneficiary, in which case TRICARE pays the bills of both recipient and donor.
 - (g) DD Form 2808 (Report of Medical Examination) and DD Form 2807-1 (Report of Medical History) completed within three months preceding the request.
 - (h) A record of serial blood pressure readings performed on five consecutive days by a TRICARE health care provider. Serial blood pressures are not required for potential liver donors.
 - (i) Basic laboratory exams, including urinalysis, complete blood count, blood urine nitrogen/creatinine, serum electrolytes, and fasting glucose obtained during initial physical evaluation by a military physician. For potential liver donors, a record of liver function tests is also required. If the potential liver donor is over 40 years old, a cardiac evaluation is needed, preferably including a graded exercise test.
 - (j) A copy of the results of compatibility testing performed at the transplanting institution.
 - (k) Statement that a follow-up medical evaluation by a military internist will be completed between 6 and 12 months after donation. The evaluation should include blood pressure, urinalysis, and serum creatinine for kidney donors and liver function tests for liver donors.
- (6) AD Army members approved under this paragraph for organ donation will be placed in an absent sick status at the time of admission to a non-Army MTF through discharge. Convalescent leave must be approved by an Army MTF. Administrative responsibility will be assumed by the appropriate Army hospital according to AR 40-400. Any absence from duty before hospital admission will be charged as ordinary leave.
- (7) An AD Army member in a non-Army MTF for the purpose of donating an organ will be transferred to an Army MTF at that point in his or her hospital course when he or she would normally be discharged. This transfer is not to be used as a means of transferring the responsibility for treatment or expenses associated with the transplant to the Army but to ensure that the Army member is medically evaluated after the organ donation to determine his or her future profile, assignments, and qualification for continued service.

e. Disposition of AD recipients.

- (1) All organ transplant recipients who are AD members of the uniformed services will be referred for a medical evaluation board before disposition from the MTF.
- (2) Except under special circumstances, these patients should be considered not worldwide deployable in physical evaluation board determinations.

f. Exclusions.

- (1) Foreign nationals are not eligible for transplant services through the Army Organ Transplant Program.
- (2) Recipients with failed transplants and who have since lost entitlement to care and beneficiaries who lose entitlement while awaiting a cadaveric organ have no status under the Army Organ Transplant Program. Exceptions may be considered under the Secretary of the Army Designee Program on a case-by-case basis.

9-2. The Army Organ and Tissue Donation Program

a. Objective. To establish Army policies and procedures for promoting organ and tissue donations.

b. Policy.

- (1) All beneficiaries of the Army health care system will be encouraged to make organ and tissue donations. Coercion or the appearance of coercion of donors or their next of kin (NOK) will be avoided at all times. Donations from minors will be accepted only under strict guidelines.
- (2) Army MTFs will establish reasonable methods for DOD beneficiaries to complete and carry DD Form 2731 (Organ and Tissue Donor Card).
- (3) Army MTFs, through Military Transplant Centers (MTCs), will participate in the congressionally established National Organ and Tissue Procurement Network that facilitates and coordinates organ and tissue donation, the recovery of donated organs and tissues, and the matching of donors and recipients.
- (4) All Army inpatient facilities will establish MOAs with an MTC and local OPOs that grant DOD recipients, including National Guard and Reserve personnel, access to organs and tissues donated by DOD donors.
- (5) Army inpatient MTFs will maintain MOAs with the MTC and the local OPO to provide organ and tissue procurement services. All MOAs should be subject to legal review before enactment.
- (6) Each USAMEDCOM RMC will ensure compliance by their MTFs with this chapter and an annual review of MOAs with MTFs, the MTC, and OPOs.

c. Procedures.

- (1) Unless prohibited medically, legally, or for religious reasons, organ and tissue donation shall be discussed with the NOK in every death in Army MTFs.
- (2) The local OPO will be notified immediately by the MTF when the potential for organ and/or tissue donation is

recognized, that is, possible irreversible brain injury or brain death. The attending physician or other health care providers directly involved in the care of the patient should not participate in procedures for recovering or transplanting the donated organs and tissues.

(3) An MOA with the local OPO will require that the OPO maintain a listing of patients who die in the MTF and record the results of action taken to secure the donation of organs or tissues from each patient who dies.

(4) The granting of privileges to local OPO physicians to recover organ/tissues is not required.

(5) If the patient who dies is over the age of majority and did not wish to donate organs or tissues, stated either orally or in writing, this desire will be honored even if it is in conflict with the wishes of the NOK.

(6) Permission of the NOK will be obtained even when a valid donation document exists. When conflict exists between the positive wishes of the donor to provide organs and tissues upon death and the wishes of the NOK, the wishes of the NOK will be honored.

(7) After notifying the local OPO to ensure its participation in the donation process, MTFs will immediately notify the MTC with which they maintain an MOA about the potential availability of donor organs and tissues from DOD donor patients. This notification permits the MTC to determine compatibility of potentially available organs with DOD beneficiaries on MTC transplant lists. Organs and tissues from DOD donors should be made available first to the DOD MTCs and then to the civilian OPO as specified in MOAs.

(8) Army incurred retrieval costs for organs or tissues accepted for transplantation to non-DOD beneficiaries will be paid by either the civilian OPO or the transplanting institution. Reimbursement for these costs shall be made payable to the MTF in which the organ and/or tissue donation occurred.

(9) The MTF will initially contact the Casualty Area Command for deceased DOD donor beneficiaries if the primary NOK is not already available at the military or civilian MTF where the deceased is located. This ensures that the primary NOK who was not present at the hospital at the time of death is notified properly by a representative of the Casualty Area Command before organ or tissue donation is solicited. The primary NOK then should be contacted telephonically by a member of the local OPO to request approval of organ or tissue donation from the deceased patient. A primary NOK's authorization of an organ or tissue gift from the deceased patient will be made by an SF 523B (Medical Record-Authorization for Tissue Donation) or State form for organ donation.

(10) Gifts of organs and tissues will be made in accordance with the laws of the State where the gift is made. If the gift is made in a foreign country, such gift will be in accordance with The Uniform Anatomical Gift Act, unless in violation with an international agreement or host nation law, in which case the latter will apply.

(11) Opportunities for a DOD beneficiary to make organ and tissue donation pledges will be made available with arrival at the first duty station, at regular physical examinations, during ID card issuance and reissuance, in all MTFs, and at military unit meetings.

(12) Informational materials to explain organ and tissue donation and blank donor cards will be provided by MTFs. DD Form 2731 will be used as the blood donor card.

Chapter 10 Orthopedic Footwear

10-1. General

Orthopedic footwear is designed to conform to the contour of abnormal feet that have been disabled or distorted. This footwear may contain specially molded inner soles or built-in appliances. It will be medically prescribed by an orthopedist, podiatrist, or pedorthist when disabled or deformed feet cannot be fitted satisfactorily with a size and type of footwear available in regular supply channels which can be modified by orthopedic adjustments. Orthopedic footwear supplied under this chapter is considered to be medical appliances. Such footwear will be furnished at no cost to the user except when furnished to family members.

10-2. Special measurement footwear

AR 32-4 and AR 700-84 contain procedures for obtaining this footwear that is required by reason of size alone. These procedures should not be confused with those in this regulation for issue and fitting of orthopedic footwear. Measurement for special measurement footwear should be made by clothing store personnel.

10-3. For whom authorized and manner provided

AR 40-400, appendix B lists the categories of persons who are authorized initial issue, replacement, and repair of orthopedic footwear. These persons are also authorized orthopedic adjustments to standard footwear.

10-4. Number of pairs of orthopedic footwear furnished

Persons requiring orthopedic footwear will be furnished two pairs initially. The kind of footwear (boots, low quarters,

athletic, etc.) furnished will depend on the type and nature of duty to be performed. Additional (replacement) footwear will only be provided when the initial issue becomes unusable.

10-5. Procedure for obtaining orthopedic footwear

a. Orthopedic footwear will be requisitioned from the Defense Orthopedic Footwear Clinic (DOFC), 666 Summer St., Boston, MA 02210. When a person requires this type of footwear, the prescribing orthopedist, podiatrist, or pedorthist will prepare DD Form 150 (Special Measurements Blank for Special Measurement/Orthopedic Boots and Shoes). This form will be sent to the installation MSO. The MSO will prepare a requisition on DD Form 1348 (DOD Single Line Item Requisition System Document (Manual)) or DD Form 1348M (DOD Single Line Item Requisition System Document (Mechanical)). The statement, 'Orthopedic initial requirement for a trial pair of orthopedic footwear,' should be entered in the remarks block. The patient's name, rank, SSN, size, and type of footwear for each foot will also be entered in the remarks block. The installation MSO will then send the requisition with two copies of the completed DD Form 150 to the DOFC. The DOFC will return the footwear for trial use with a DOFC Form 10 (Fitting Report-Special Footwear).

b. When the person's foot cannot be clearly and fully described, a cast may have to be prepared for one or both feet. This will enable the DOFC to construct the proper footwear cast. At installations where plaster casts cannot be made, they may be obtained locally from the VA or commercial sources with local operating funds. Casts will be properly packaged and sent to the DOFC with the DD Form 150 and DD Form 1348.

c. A medical officer (preferably an orthopedist, a podiatrist, or a pedorthist) will test-fit the trial pair of footwear before issue to the user to make sure the footwear meets prescribed specifications for correcting the disability. DOFC Form 10 will be completed and returned to the installation MSO. When the footwear is issued, entry will be made on SF 600 or SF 509 in the inpatient treatment record (ITR) per AR 40-66. For other than AD personnel, an entry will be made in the ITR or OTR of the individual concerned. For enlisted personnel, an entry will be made on DA Form 3078 (Personal Clothing Request), according to AR 700-84 for personal footwear or AR 710-2 for organizational footwear, depending on the type of issue.

10-6. Replacement orders

Before ordering replacement footwear, review the Defense Enrollment/Eligibility Reporting System to verify patient eligibility. In addition, a physical examination should establish that footwear previously prescribed remains satisfactory. If no changes are required, DD Form 150 will be marked 'Orthopedic replacement requirement.' The prescribing medical officer will indicate any required changes on a new DD Form 150, conspicuously marked 'Revised.' The installation MSO will then prepare a requisition for the replacement footwear according to paragraph 10-5 and send it to the DOFC. An Army member may be located in an area where no medical officer is available and the previously prescribed footwear is satisfactory. If so, a request for replacement will be sent directly to the DOFC without a medical examination.

10-7. Delivery of footwear after patient transfer

When orthopedic footwear is delivered for a patient who has been transferred, it will be shipped to the MSO at the patient's current duty station. The supporting MTF will assist in fitting the footwear. If the patient has been transferred to a VA MTF, the footwear, fitting report, and any other pertinent data will be sent to the MTF director. If the patient has been discharged, the footwear and all pertinent data will be sent to the director of the appropriate VA regional office.

10-8. Orthopedic adjustments to standard footwear

a. Adjustments to standard footwear may be furnished without charge to the person when prescribed by a medical officer. However, the patient will procure the standard footwear to which the orthopedic adjustment is to be made.

b. Adjustment may be made by Army shoe repair shops or by commercial repair shops using local operating funds.

10-9. Repair of orthopedic footwear

a. Footwear that requires more than minor repairs will be sent to the DOFC. Based on information furnished by the medical officer, the installation MSO will prepare a requisition according to paragraph 10-5, indicating the required repairs. This requisition will be sent with the footwear to the DOFC.

b. Minor repairs (excluding maintenance repairs such as normal soling and heeling) are authorized without charge to the individual. Repairs may be made by Army shoe repair shops or by commercial repair shops using local operating funds.

10-10. Orthopedic lasts and patterns

Special lasts and patterns required in making orthopedic footwear for authorized personnel will be kept on file at the DOFC.

10–11. Movement of active duty members to a DOFC

AD patients will be moved to the DOFC when casts cannot be properly prepared locally or their presence is otherwise required. These members may be moved in a duty or patient status. Movement will be by Government transportation when available. Advance arrangements for the required services will be made with the DOFC.

Chapter 11 Pharmacy Management

11–1. Applicability

This chapter applies to Army MTFs worldwide.

11–2. Responsibilities

a. The MTF commander is responsible for operation of the pharmacy and will exercise careful supervision over all phases of its operations. This includes employment of recognized professional procedures and establishment and aggressive pursuit of those policies that ensure conformity with the highest standards of the pharmaceutical profession. The commander will ensure that-

(1) Supervision is exercised directly, either by—

(*a*) A subordinate officer or civilian who is a graduate of a recognized school or college of pharmacy and licensed to practice pharmacy in one of the states of the United States (U.S.), Puerto Rico, or the District of Columbia, or

(*b*) A Medical Corps or civilian physician acting as officer in charge or equivalent status when no pharmacist is on duty at the facility.

(2) Policies are established to ensure—

(*a*) Rational prescribing, taking into consideration pharmacoeconomic aspects of various medication alternatives so that health care providers utilize the most cost-effective therapies at the MTF.

(*b*) That quantities of drugs prescribed do not exceed amounts required to provide sound medical treatment.

(*c*) That drug dispensing is based on a formulary system.

(*d*) That the MTF follows guidance from the DOD Pharmacy Board of Directors and decisions made by the DOD P&T Committee to ensure that the provision of pharmaceutical care and the pharmacy benefit at the MTF follow all DOD/ASD(HA) directives and policies.

b. The Chief, Pharmacy Services or Director, Department of Pharmacy—depending upon the local designation—will be charged with the duties of recognizing, identifying, selecting, ordering, preparing, safeguarding, evaluating, and dispensing all pharmaceutical substances of whatever kind and combination used in preventive, curative, and diagnostic medicine. The chief and his or her staff will be responsible for keeping abreast of new developments in the field of pharmacy and for operating the pharmacy in compliance with Federal laws, accreditation standards defined by the JCAHO, and standards of pharmaceutical care within the community. In doing so, the chief will be responsible for—

(1) Assisting and advising health care providers in the writing of prescriptions, medication orders, and other matters involving the use or misuse of medications.

(2) Conducting and documenting inspections of areas stocking pharmaceuticals. In outlying clinics that have a pharmacist assigned, inspections may be conducted by that pharmacist or a designee and a copy of the inspection report forwarded to the main pharmacy. Recurring problems and trends not corrected by department or service chiefs will be referred to the appropriate person/group within the MTF's specific IOP structure.

(3) Maintaining adequate reference material for use by pharmacy personnel and other professional staff served by the pharmacy.

(4) Disseminating information to the professional staff concerning advances in the field of pharmacy and related matters.

(5) Assisting the P&T Committee in developing a policy for local management and control of pharmaceutical industry activities. In the event that a USAMEDCOM corporate policy is published, the local policy will support the USAMEDCOM policy.

(6) Disseminating via appropriate media (for example, memorandums, electronic mail, etc.), pharmacy information on drug items, preparations available for use, prescribing policies, and items of interest to the medical staff.

(7) Maintaining and dispensing investigational drugs according to AR 40-7.

(8) Operating a pharmacy sterile products program within the hospital to include the preparation and delivery of pharmaceutical sterile products to patient care areas.

(9) Operating a unit dose or other point of use drug distribution system to ensure a safe, efficient, and economical method of drug distribution.

(10) Operating an ambulatory pharmacy service that fills and dispenses prescriptions to outpatients.

(11) Counseling and advising patients and the professional staff on the appropriate use of medications, including

interactions and cautions related to the use of alternative forms of medicines such as dietary supplements and herbal remedies.

(12) Conducting staff assistance visits to outlying clinic pharmacies.

(13) Participating in the MTF medication use evaluation program.

(14) Representing the pharmacy service on various committees used by the MTF to improve information management, utilization management, and patient outcomes.

11-3. Monetary collections for medicine

The pharmacy will not serve as a monetary collection agency for drugs or pharmaceutical services. However, the pharmacy will assist the command's Third Party Collection Program (TPCP) office in billing third party insurers for prescriptions authorized under the TPCP.

11-4. Personnel

a. The Chief, Pharmacy Services will ensure that only qualified persons compound and/or dispense pharmaceutical preparations. Only graduates of accredited civilian pharmacy schools will be assigned professional duties in the pharmacy. Technicians who have successfully completed a course of instruction at a pharmacy specialist course of the Armed Services, a civilian course of equivalent scope, or on the job experience may be assigned technical duties in the pharmacy. Local, on-site training of civilian personnel to fill technician positions is permitted. Military and civilian pharmacy technicians are encouraged to meet all requirements for the civilian-based Pharmacy Technician Certification Board. Documentation of training will be maintained on file within the pharmacy.

b. The range, variety, and complexity of drugs dispensed in both hospital and clinical settings have become increasingly significant and require professional competence and supervision; therefore, one or more licensed pharmacists will be assigned primary duty at all full-service military pharmacies (those that dispense other than prepackaged medications to soldiers or other beneficiaries) to supervise the prescription-dispensing process. At installations that do not have a pharmacist assigned, the pharmacy may be operated—

(1) By part-time licensed pharmacy officers who are assigned other primary duties; or

(2) By part-time civilian licensed pharmacists; or

(3) By dispensing physicians or dentists.

c. Trained pharmacy specialists—either enlisted or civilian—may be used in pharmacies provided they function under the direct supervision of licensed pharmacists or dispensing physicians or dentists and that the individual providing the direct supervision checks all prescriptions before they are dispensed. It is recommended that all medications being taken by the patient be reviewed before the medication is dispensed.

d. Troop medical clinic pharmacies may be operated by trained pharmacy specialists working independently provided only prescriptions for AD soldiers are filled from a limited list of drugs.

11-5. Basic core formulary and committed use requirement contracts

a. All MTFs will implement the DOD Basic Core Formulary (BCF) as a base line, in accordance with current policy from ASD(HA) and the DOD P&T Committee. The BCF medications will be available to all beneficiaries, regardless of status or residence, unless restricted for clinical reasons. The BCF may be supplemented by the local commander to meet the needs of the facility.

b. MTF commanders will actively ensure compliance with the terms of contracts for pharmaceuticals established by Defense Supply Center Philadelphia in conjunction with the Pharmacoeconomic Center and the DOD P&T Committee. Additionally, MTF commanders will not permit local prescribers or pharmacy industry initiatives to supplant or circumvent contract requirements.

11-6. Pharmacy and Therapeutics Committee

a. *Establishment.* A P&T Committee will be appointed by the commander of a health care system or each individual hospital.

b. *Composition.* The committee will include a mixture of clinical and administrative staff so that all specialties are represented to the maximum extent possible.

c. *Objective.* The primary objectives of the P&T Committee are—

(1) *Advisory.* The committee recommends the adoption of and assists in the formulation of broad professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters related to therapeutic agents.

(2) *Educational.* The committee recommends or assists in the formulation of programs designated to meet the needs of the professional staff for current knowledge on matters related to therapeutic agents and their use.

d. *Functions.* The functions of the P&T Committee are to—

(1) Advise the commander and the professional staff in all matters pertaining to the use of therapeutic and diagnostic agents.

- (2) Advise the commander and the professional staff in the selection of therapeutic agents which are the most efficacious and cost effective.
- (3) Recommend local prescribing policies based on professional, economic, and other appropriate administrative considerations.
- (4) Evaluate clinical data regarding new therapeutic agents proposed for use in the hospital.
- (5) Prevent unnecessary duplication in stockage and use of the same basic therapeutic agent or its combinations.
- (6) Establish a formulary of therapeutic agents and provide for its continual review and revision.
- (7) Propose educational programs for the professional staff on particular matters related to therapeutic agents and their use.
- (8) Review a summary of the Quality Control Messages furnished by the Chief, Pharmacy Service and disseminate all pertinent information to members of the professional staff.
- (9) Monitor all adverse drug events and make recommendations to prevent their occurrence. Determine which events are reportable and forward reports to the FDA and manufacturer as appropriate.
- (10) Monitor the medication use evaluation program and make recommendations to optimize drug use.
- (11) Monitor the use of controlled substances.
- (12) Develop a standard list of chemical symbols and abbreviations for use in prescribing medications.
- (13) Review and recommend prescribing lists, by individual drugs, category of drug, or, if more convenient, by facility-specific exceptions to an open formulary for non-physician health care providers in accordance with AR 40-48 or as required by other regulations.
- (14) Recommend policies to govern the access, conduct, and activities of pharmaceutical industry representatives within the MTF.

e. New therapeutic agents. Requests for new therapeutic agents will be submitted to the P&T Committee on DD Form 2081 (New Drug Request) or alternate locally approved form.

f. Meetings. The P&T Committee will meet as often as required, but no less frequently than quarterly.

g. Records. The P&T Committee will keep minutes of its meetings and forward a copy of the minutes to the Director, DOD Pharmacoeconomic Center, ATTN: MCCS-GPE, 1750 Greeley Road, Bldg 4011, Room 217, Fort Sam Houston, TX 78234-6190.

11-7. Therapeutic dietary supplements

a. Therapeutic dietary supplements are specially manufactured formulas used in many instances as the sole source of nutrition for patients and are considered therapeutic agents subject to review by the P&T Committee and approval by the MTF commander.

b. Inpatients will be provided therapeutic dietary supplements consistent with appropriate professional care as directed by a privileged practitioner. The NCD will be responsible for the preparation and distribution of these items. However, if any medication is to be added, the final preparation will be compounded and labeled by the pharmacy service.

c. Outpatient use of dietary supplements will be reviewed on an individual basis for each patient by the P&T Committee and approved by the MTF commander. These items will be dispensed by the MTF pharmacy service or NCD as appropriate.

d. Patients with aminoacidopathies consisting of phenylketonuria, maple syrup urine disease, homocystinuria, histidinemia, and tyrosinemia will be provided special amino acid modified nutrient preparations by the pharmacy or dietary service upon presentation of a valid prescription.

11-8. Improving organizational performance

a. Performance improvement process. The Chief, Pharmacy Services will implement an internal performance improvement process that will demonstrate improvement in pharmacy services. This process will be integrated with the MTF IOP structure and documentation will provide evidence of ongoing improvement.

b. Recording and reporting medication errors. (See the glossary.) The following classification of errors was developed by the National Coordinating Council on Medication Error Reporting and Prevention and will be utilized when medication errors are noted. Use of these categories helps ensure standardization with the civilian community as they are compatible with the Web-based medication error-reporting program currently available:

- (1) Category A: Circumstances or events that have the capacity to cause medication error.
- (2) Category B: A medication error detected after the medication is dispensed but not taken by or administered to the patient. These errors will be recorded and evaluated using the pharmacy IOP structure.
- (3) Category C: A medication error occurred that reached the patient but did not cause patient harm.
- (4) Category D: A medication error occurred resulting in the need for increased patient monitoring but no patient harm.
- (5) Category E: A medication error occurred resulting in the need for treatment or intervention and caused temporary patient harm.

(6) Category F: A medication error occurred resulting in initial or prolonged hospitalization and caused temporary patient harm.

(7) Category G: A medication error occurred resulting in permanent patient harm.

(8) Category H: A medication error occurred resulting in a near-death event (for example, anaphylaxis, cardiac arrest).

(9) Category I: A medication error occurred resulting in patient death.

c. Category C through I errors. Medication errors in categories C through I will be documented on DA Form 4106 (Quality Assurance/Risk Management Document) (see AR 40–68 for instructions on the use of this form) or the local equivalent. The attending prescriber will be notified, and the error will be evaluated using the pharmacy IOP structure. The pharmacy will refer these and the necessary supporting records as appropriate within the MTF-specific IOP structure. A root cause analysis, in accordance with JCAHO standards, will be conducted on any error in categories G through I and as deemed appropriate by the specific MTF. Copies of the form may be provided to individuals, services, or departments deemed appropriate to clarify and rectify the problem, according to AR 40–68.

11–9. Controlled substances

a. Controlled substances are drugs so designated by the Drug Enforcement Administration (DEA). The DEA assigns controlled substances to one of five schedules according to the abuse potential and degree of control required. A list of controlled substances in each schedule and changes are published in the Federal Register and in the SB 8-75 series.

b. MTF commanders may designate items as locally controlled if they deem them subject to potential abuse or diversion. The method of accountability for such items will be either as Schedule II or Schedule III-V as determined by the commander.

c. The use of methadone for drug dependency withdrawal or maintenance of narcotic addiction is not authorized in Army MTFs. Methadone may be utilized for extreme uncontrolled discomfort of rapid withdrawal or for the temporary maintenance of patients hospitalized for the treatment of conditions other than narcotic addiction in accordance with the USC and the CFR. There is no restriction on the use of methadone when it is used for analgesia.

d. Amphetamines and methamphetamines are prohibited from being prescribed as anorexic agents. Also, any medication used solely for its anorexic activity is prohibited from use in Army MTFs. This does not preclude the use of alternative medications with weight loss effects when medically indicated and used in a structured program to treat obesity.

11–10. Individuals authorized to write prescriptions

a. The following categories of personnel are authorized to write prescriptions:

(1) Uniformed and civilian physicians, dentists, veterinarians, and podiatrists engaged in professional practice at uniformed services MTFs.

(2) Civilian physicians, dentists, and podiatrists, not assigned to a uniformed services MTF but licensed in the jurisdiction of their practice and treating personnel eligible for care in the Military Health System (MHS).

b. The following personnel are authorized to write prescriptions only for selected medications as established under the provisions of AR 40-48 and/or approved by the local commander:

(1) Uniformed and civilian optometrists, nurses, physician assistants (PAs), physical therapists (PTs), occupational therapists (OTs), and pharmacists engaged in professional practice at uniformed services MTFs and privileged to prescribe medications.

(2) Civilian personnel, not assigned to a uniformed service MTF but licensed in the jurisdiction of their practice and treating personnel eligible for care in the MHS, may prescribe to the extent authorized by State law and by policies for equivalent staff non-physician health care providers.

(3) Other non-physician health care providers not listed above but assigned to a uniformed service MTF and granted limited prescribing privileges.

(4) Retired uniformed practitioners who are not in a professional practice but with a valid State license may prescribe only non-controlled substances for themselves or their family. Retired medical personnel not in a professional practice and not having a valid State license will not prescribe medications.

c. Prescriptions, written by licensed civilian practitioners not assigned to a uniformed service MTF, for personnel eligible for care in the MHS will be honored at Army MTFs if the prescribed medication is on the MTF's formulary and meets local dispensing policies.

(1) A policy relative to filling civilian prescriptions will be established and announced by the commander. The policy should coincide with those regulating staff prescribers except in those MTFs located in a State where the law limits product substitution by the pharmacist. In such areas, the generic equivalent will not be substituted for a brand name drug on a civilian prescription without prior approval of the prescriber.

(2) Filling a prescription written by a civilian practitioner does not imply knowledge of or responsibility for a patient's medical condition. Under no circumstances will civilian prescriptions be countersigned or rewritten by military practitioners. Special or non-formulary drug requests will not be submitted by military providers on behalf of prescriptions from civilian providers that are written for non-formulary medications.

d. A distance factor or geographic boundary limitation will not be a basis for denying prescription services. MTF pharmacists will adhere to all applicable Federal and state laws when filling prescriptions originating from outside the state.

e. Individuals with prescribing privileges are not authorized to prescribe controlled substances for themselves or members of their families.

f. Non-physician health care providers may, when authorized by the commander, dispense the drugs they are privileged to prescribe after the drugs are properly prepackaged and labeled.

11-11. Signatures

a. With the exception of physician order entry via the Composite Health Care System (CHCS), no prescription or order will be filled in the pharmacy unless it bears the signature of an individual authorized to write prescriptions. Signature stamps are not authorized for prescriptions. The pharmacy service will maintain a system that allows their staff to validate the signature of individuals privileged to write prescriptions within their MTF.

b. Subject to such restrictions as may be imposed by the local commander, the pharmacy will honor bulk orders for drugs other than controlled substances when signed by a designated representative of the officer in charge of the patient care area. The name and signature of each designee must be provided to the pharmacy in advance.

c. Orders for controlled substances will be signed by individuals authorized to write prescriptions or by a registered nurse.

d. MTFs with electronic ordering capability may use electronic signatures if security measures are provided.

11-12. Dispensing

a. *General.* The MTF commander will ensure adherence to the DOD Tri-Service pharmacy policy guidance for dispensing medications. Wards, clinics, and other activities within the MEDCEN/MEDDAC will normally use the pharmacy as the source of supply for drugs required for administration within the MTF. In addition, the pharmacy dispenses such preparations as may be authorized and required directly to inpatients and outpatients.

b. *Prescription forms.*

(1) DD Form 1289 (DOD Prescription) is the standard form. Prescription forms provided by or preprinted by a commercial company will not be used in Army MTFs.

(2) Information pertaining to drug manufacturer, lot number, and expiration date is not required on any DD Form 1289 written in an Army MTF if there is a drug recall procedure that can be readily implemented.

(3) The MTF commander may authorize use of a locally developed multiple prescription form.

(4) The MTF commander may authorize use of other official forms for use in prescribing medications (for example, SF 600, SF 558 (Medical Record-Emergency Care and Treatment), or DA Form 4256 (Doctors Orders), etc.).

c. *Logs.* A log or automated documentation of all medications placed in storage counting cells such as Baker^(tm) or Drug-o-matic^(tm) will be maintained, to include initials of the pharmacist or technician checking the filled cell. Disposition of these logs will be according to paragraph 11-23.

d. *Bulk drug orders.* DA Form 3875 (Bulk Drug Order), a local form, or an automated system will be used for ordering all non-controlled drugs or preparations in bulk quantities for use in a ward, clinic, or other activities. Items requiring maintenance of a stock record card will be issued only upon receipt of a properly written and authenticated prescription blank or locally approved form. A mechanism to review and approve medications for stockage in these areas should be established in accordance with the local IOP structure. At least annually, the appropriateness of these items as well as their stock levels should be reviewed and approved.

e. *Dispensing procedures.*

(1) All legend drugs will be dispensed only upon receipt of a properly written or automated prescription.

(2) MTFs will follow a generic dispensing policy. Orders written by staff providers for trade name drugs will automatically be dispensed with the generic equivalent when possible.

(3) The MTF will develop written procedures for dispensing controlled medications that comply with Federal laws and Army regulations.

(4) A policy will be established that allows prescribers to order up to a 90-day supply of maintenance medications. The prescriber will maintain the flexibility to determine dispensing quantities for individual patients. Prescriptions will be filled as written up to the 90-day supply.

(5) All items provided to outpatients will be dispensed in accordance with the Poison Prevention Packaging Act of 1974 and policies prescribed by the commander and will be labeled to include the legend 'KEEP OUT OF THE REACH OF CHILDREN.'

(6) During the hours that the pharmacy is closed, amounts of drugs sufficient to provide treatment until pharmacy services are available or to complete a therapeutic regimen may be dispensed directly from an after-hours walk-in clinic or from the EC. All prescription medications must be checked by the prescriber before being given to the patient. All prescription containers will be labeled to show the identity of the facility, date filled, directions to the patient, name of drug, (unless prescriber directs otherwise), quantity issued, and the name of the patient and prescriber. Repackaged medications will include a lot number and expiration date.

f. Self-care programs.

(1) At the discretion of the commander, individual MTFs are permitted to establish self-care programs utilizing nonprescription medications. The programs will be strictly defined and controlled as to both medications included and quantities that can be dispensed.

(2) A self-care program is defined as one which includes the participation of a non-physician health care provider who authorizes dispensing selected over-the-counter (OTC) medications.

(3) Items dispensed will be limited to OTC medications and packaging will comply with Federal law.

(4) To the maximum extent possible, items dispensed will be entered onto the patient's medication profile.

g. Refill prescriptions from other MTFs. Non-controlled prescriptions originally filled at one MTF may be refilled at another as long as the pharmacist takes into account the type of medication and the method used for recording the refill. A system will be in place to notify the original MTF of the refill action. Where two or more MTFs share the same computer database, prescriptions for controlled substances filled at one MTF may be refilled at another as long as there is agreement or a memorandum of understanding between all MTFs on that database.

h. The use of robotics. The use of robotics in the dispensing process is encouraged, as it reduces the potential for dispensing errors and allows for a redistribution of pharmacy staffing to more pharmaceutical care-related functions. Physical security considerations must be addressed prior to implementing this technology. In some cases, where current regulations are lacking, policies addressing the storage of medications within these machines must be generated at the local level. Additionally, logs must be maintained as outlined in paragraph 11-12c.

i. When a child may pick up his or her prescription. The age at which a child may pick up his or her prescription from the pharmacy without being accompanied by a parent or guardian will be determined by the dispensing pharmacist in accordance with the definition of a "patient with decision-making capacity." (See the glossary, section II, "Patient with decision-making capacity.")

11-13. Prescription writing

a. Prescriptions will be stamped, typed, or written in ink and signed in ink by an authorized prescriber. As an exception to this rule-

(1) Electronic prescriptions generated through CHCS, to include prescriptions for Schedules II through V controlled substances, may be filled by the pharmacy contingent upon guidelines established in ASD(HA) Memorandum dated 31 May 1990, Subject, Schedule II Controlled Substances Waiver for Electronic Approval and letter, Drug Enforcement Administration, dated 26 Mar 1990. (See app A.) Otherwise, prescriptions for Schedule II substances require an original prescription.

(2) MTFs may accept prescriptions electronically from civilian prescribers outside the facility according to appropriate State laws.

(3) A carbon, facsimile, or electronic copy of prescription orders noted for a patient at the time of discharge in the nursing notes-to include prescriptions for Schedules II through V controlled substances-may be filled by the pharmacy.

(4) In the event that a multiple prescription (military or civilian) is presented to the pharmacy and the pharmacy does not stock all the medications ordered, the pharmacy will make a copy of the prescription for the pharmacy's files. The original prescription will be annotated as to which items were filled and returned to the patient. An original prescription must be on file for controlled substances.

b. Prescriptions will be dated and signed on the day when written and bear the full name, address, and telephone number of the patient, and SSN of the sponsor. When patients present more than one prescription for other than controlled substances, the full name must be on all, with the above required information on at least one of the prescriptions. DD Form 1289 will contain only one item per form.

c. In accordance with current policies, authorized military and DOD providers who are authorized to prescribe, dispense, and administer controlled substances will record their DEA number or social security number on all prescriptions written for controlled substances in the course of their official duties. The prescriber will place his or her signature; branch of service; DEA number or social security number; and name stamped, typed, or hand printed on each controlled substance prescription. When working in other than their official capacity (that is, off-duty employment), military and DOD civilian MTF providers will be required to have their own personal DEA number. Contract prescribers working in MTFs are not officials of the Armed Forces and, therefore, must have a DEA number to prescribe controlled substances within the MTF.

d. Prescriptions written for children 12 years of age and under will include the child's age.

e. Prescriptions originating in Army MTFs will be written using the metric system.

f. Prescriptions for controlled substances written at Army MTFs will have the amount prescribed shown both in numerals and spelled out in words.

g. Prescriptions written by non-physician health care providers must bear the typed, stamped, or printed statement: 'May be filled at any MHS pharmacy that recognizes provider's privileges.'

h. Prescriptions written by civilian or military veterinarians for Government-owned animals (GOAs) will be honored at Army MTFs. Prescriptions for privately-owned animals (POAs) will not be filled.

i. Prescriptions written by foreign licensed practitioners and brought into MTFs located within the U.S. may be

filled according to the appropriate State law. In MTFs located outside the U.S., the laws of the foreign country and the terms of the applicable treaty and/or administrative agreement between the U.S. and the foreign country concerned will be followed.

j. A system designed to ensure eligibility of outpatients will be established. Also, a system to ensure accurate identification of outpatients at the time they receive prescribed medications will be established.

k. Where available, the pharmacy data transaction service (PDS) will be utilized to screen an eligible patient's prescription against the patient's total drug profile for drug interactions, drug overlaps, drug dosage, and patient compliance. Additionally, retrospective, concurrent, and prospective drug utilization reviews will be accomplished.

11-14. Mailing prescriptions

The routine mailing of prescriptions to patients who are authorized to use either the National Mail Order Pharmacy (NMOP) or the TRICARE retail pharmacy network is discouraged, but not prohibited. Exceptions are limited to cases of individual patients with extraordinary need or hardship who are not eligible for NMOP through TRICARE or the base realignment and closure pharmacy benefit. If prescriptions are mailed, they must be in compliance with appropriate Federal law.

11-15. Refilling prescriptions

The local commander will establish a prescription refill policy that best supports the command. The policy will be consistent with Federal law and will comply with standards established by DOD.

11-16. Accounting for controlled substances used in the manufacture of pharmaceutical preparations

DD Form 1289 or an equivalent automated record will be used to account for all controlled substances used in the manufacture of pharmaceutical preparations. Such orders will be authenticated and signed by a pharmacist and will be filed in the appropriate prescription file.

11-17. Labeling

a. A label will be prepared for each prescription dispensed to individuals and will be securely affixed to the container prior to dispensing. The information on the label will be consistent with Federal law.

b. Supplemental labels will be affixed to prescription containers as dictated by the pharmacist's professional judgment and the current standard of pharmacy practice. Such labels will be used to warn individuals of potential interactions or side effects, special handling or storage requirements, or poison considerations. (See table 11-1.)

c. Labeling requirements for drugs issued in bulk to wards, clinics, and other authorized agencies will be prescribed by the commander. The container label will include the generic name and strength, manufacturer, lot number or locally assigned lot number, and expiration date.

d. OTC medications dispensed through a self-care program will be dispensed in the manufacturer's original package without additional labels attached.

e. Labels for intravenous admixture solutions prepared by the pharmacy service will comply with Federal law and appropriate standards of practice.

11-18. Numbering and filing

All hard copy prescriptions and orders filled by the pharmacy will be placed in files established and maintained in the pharmacy. Prescriptions will be numbered serially and initialed by the individual who checked them. Three or more series of numbers will be used; one series for Schedule II controlled substances, alcohol, and alcoholic liquors; one series for Schedules III, IV, and V controlled substances; and one series for all others. A corresponding file will be established for each series of numbers. Pharmacies using CHCS or any other computer system will develop a suitable alternative method to number, check, and file prescriptions.

11-19. Stock record

The pharmacy will maintain a record of receipts and expenditures of all controlled substances, ethyl alcohol and alcoholic liquors, and of such other drugs as may be designated by the commander. A separate record will be maintained on DA Form 3862 (Controlled Substances Stock Record) for each dosage form in which the item is supplied except where an equivalent locally approved automated accounting record (AAAR) is used.

11-20. Disposition of drugs collected from patients

a. All drugs brought in by patients admitted to the wards will be collected by nursing personnel. When possible, these drugs will be given to a member of the patient's family. Drugs not given to a family member will be turned in to the pharmacy for disposition as follows.

(1) If the medication is carried in stock by the hospital, the pharmacy has the option of either discarding the medication or storing the medication until the patient is discharged. If the patient has the same medication prescribed upon discharge and the retained medication is suitable for re-issue, then it may be returned to the patient with appropriate labeling. Medications not reissued will be destroyed under locally established destruction procedures.

(2) If the medication is not stocked by the hospital and the prescription came from a military pharmacy, it will be stored until the patient is discharged. It may be returned to the patient upon discharge if approved by the attending physician.

(3) If the medication was purchased by the patient from a civilian pharmacy, it will be stored until the patient is discharged. It will be returned to the patient at time of discharge if requested by the patient.

(4) Turn in of controlled substances should be performed with a physical count and receipt system.

(5) Any medications held for more than 30 days after the patient is discharged will be destroyed under locally established destruction procedures.

b. Except as noted below, drugs collected from inpatients and stored at the pharmacy will not be used to treat patients. All medications to be administered to inpatients will be from pharmacy stocks. Patients may be allowed to utilize their personal medications when alternative drugs stocked in the pharmacy are not acceptable. The personal medications must be positively identified by pharmacy personnel and there must be a written order from a responsible practitioner.

11-21. Self-administration

Patients may be allowed to administer medications to themselves when requested in writing by the prescriber.

11-22. Returns and destruction of drugs, biologicals, and reagents

a. A local policy will be developed for the return and/or destruction of drugs, biologicals, and reagents. The policy will be in compliance with appropriate Federal law and AR 40-61.

b. Controlled substances identified for destruction will be reported to the commander for disposition approval. Destruction will be accomplished in the presence of a witnessing officer. A record of such destruction, signed by the witnessing officer, will be filed in the controlled substances file as authority for dropping the items from inventory.

11-23. Inspection and disposition of prescription files and records

a. Inspection. Prescription and allied records will be subject to inspection by inspectors and higher echelon commanders at all times.

b. Disposition. Prescription files, controlled substance records, and other records maintained in pharmacy will be retained and disposed of according to AR 25-400-2. Any alternative method of storage and disposal must be approved by the MTF's records management officer.

11-24. Investigational drugs

Only FDA-approved medications will be procured for use in Army MTFs except when investigational drugs (see Glossary) are used according to AR 40-7 and AR 40-38. The procedures outlined in AR 40-7 will be used for the one-time emergency use of an investigational drug.

11-25. Procedures regarding controlled drugs

a. The AMEDD currently has in effect regulatory guidance that exceeds requirements of Federal law and JCAHO standards. Specific guidance for inventory, control, and accountability of controlled substances are included in appendix B. It is essential that commanders place emphasis on the audit and inventory procedures outlined in this appendix.

b. Periodic reviews to detect overuse and/or abuse of controlled substances will be conducted and findings reported through the P&T Committee.

c. Controlled substance histories recorded in patient medication profiles for prescriptions from civilian practitioners will be made available to MTF prescribers upon their request.

d. The Controlled Substance Act (P.L. 91-513) requires facilities that maintain controlled substances to conduct an inventory of all controlled substances every 2 years. The inventory can be accomplished without performing an additional inventory if the MTF designates the first monthly inventory every other FY as the biennial inventory.

11-26. Patient counseling

a. Pharmacists will conduct prospective drug utilization reviews and offer counseling to all patients receiving a new prescription. Counseling on refill prescriptions will be performed when appropriate.

b. Dispensing pharmacists are encouraged to provide printed patient information sheets on medications dispensed whenever deemed appropriate and to supplement verbal counseling. As a minimum, MTF pharmacies will initiate a program to educate DOD beneficiaries on the access to printed patient information sheets for prescription medications, such as posting signs in the outpatient pharmacy alerting patients to the availability of such information.

c. MTF pharmacy personnel should be sufficiently versed on the use, potential side effects, and drug interactions associated with herbal preparations, vitamin/mineral supplements, or other dietary supplements commonly used by DOD beneficiaries. Appropriate references should be readily available to answer questions from both patients and medical staff regarding these products. Mechanisms should be in place within the MTF to screen patients taking these supplements whenever medical histories are taken. Health care providers will document adverse events believed to be

due to the use of dietary supplements in the patient's medical record and notify the P&T Committee. When appropriate, providers, or the P&T Committee, will report these events to the FDA.

11-27. Drug samples

Drugs samples provided by a pharmaceutical company, regardless of value, are classified as gifts and therefore come under the provisions of AR 1-100.

Table 11-1
Examples of drug reactions and supplementary labels

	Drug group—areas of reaction	Labels (See note.)
1.	a. Sedatives, tranquilizers, antidepressants	This medication may cause drowsiness. If affected, do not drive a vehicle or operate machinery. AVOID ALCOHOL.
	b. Antihistamines	
	c. Narcotic analgesics	
2.	a. Hypnotics and sedatives	Avoid taking alcohol with this medication unless advised by physician.
	b. Oral hypoglycemic drugs	
	c. Monoamine oxidase inhibitors	
	d. Disulfiram	
3.	Insulin, ampicillin suspensions, etc.	Refrigerate. Do not freeze.
4.	Items with short shelf life	Discard contents after XX/XX/XX.
5.	Drugs which cause serious phototoxic reactions when patients exposed to sunlight	Avoid exposure to direct sunlight while taking this medication.

Notes:

¹ Labels such as "Shake well before using" and 'For external use only' will also be used where appropriate.

Chapter 12

Use and Control of Psychological Test Materials

12-1. Purpose and scope

This chapter prescribes policies on the use and control of psychological test materials. This policy is applicable at all levels within the DA where psychological test materials are utilized.

12-2. Objective

The objective of this chapter is to identify a class of specialized professional materials and to provide guidance in the proper management of services using psychological test procedures.

12-3. Policy

a. All qualified psychologists, as defined in the Glossary section of this regulation, are responsible for advising professional and staff personnel in the appropriate use of psychological tests. This includes direct responsibility for the use, security, and control of psychological test instruments in the functions of patient care, clinical investigations, personnel screening, and community and command consultation.

b. Psychological test results include sensitive, private, and confidential information. Every effort will be made to ensure that the procedures used in obtaining, recording, and reporting of psychological test results are appropriate, and that the test results are not misused. The use of psychological testing techniques by unqualified, non-privileged persons is prohibited.

c. Only qualified psychologists (see Glossary) are authorized to supervise the administration, scoring, and interpretation of psychological testing.

d. Other users of psychological tests (see Glossary) must be able to document formal, supervised training in the use of psychological tests, or use psychological tests under the direct supervision of a qualified psychologist. In addition, these individuals must possess a working knowledge of the principles of test measurement and be familiar with the literature pertaining to the psychological tests employed. Health care professionals who demonstrate and can document appropriate training, skill, and knowledge in the use of psychological tests, and who are granted clinical privileges to do so, may utilize psychological tests.

e. Users of psychological test procedures will adhere to the professional requirements set forth in the publications of the American Psychological Association entitled 'Standards for Educational and Psychological Testing,' 'Ethical Principles of Psychologists,' and 'Specialty Guidelines for the Delivery of Services by Clinical, Counseling, Industrial, and School Psychologists.'

f. Nonadherence to the policies and procedures of this regulation may jeopardize medical, legal, and administrative actions based on or supported by psychological test results. In addition, nonadherence could raise issues such as professional misrepresentation or misconduct, unlawful invasion of privacy, negligence in the safeguard of private information, or discriminatory health care practice.

g. Monitoring of psychological test use must be included in the IOP structure.

h. The use of computerized psychological test administration, scoring, and interpretation services requires the direct supervision of a qualified psychologist.

i. Psychological test interpretation and reporting will be performed only by individuals who are qualified and granted privileges to do so by the MEDCEN/MEDDAC credentials committee, according to AR 40-68.

12-4. Supplemental conditions of psychological test use

The following conditions supplement the basic guidance on the use and control of psychological test material, equipment, data, and reports:

a. Test instruments, methodology, materials, and equipment-

(1) Will be accessed only by those persons with professional interests who safeguard their use and security.

(2) Will be secured under locked storage when not in use.

(3) May not be removed from the physical premises of the professional agency unless under the direct supervision of a qualified psychologist.

(4) Will not be reproduced in any fashion.

(5) Will not be described or displayed to others in ways that might invalidate their use.

(6) Will not be administered to, or practiced on, the general public, including family members or friends. (It is acknowledged that practice subjects may be used in approved training programs.)

(7) Will be used only in situations having established formal and local referral procedures to either a qualified psychologist or to other mental health professionals as outlined in paragraphs 12-5*b* through *d*.

(8) Are subject to control, recall, and use under the direction of the responsible qualified psychologist.

(9) Are disposed of by locally appropriate destruction means when they are no longer usable due to obsolescence, defacement, or state of disrepair.

b. Acquired raw test data, test scores, and user aid documents (that is, test answer sheets, profile sheets, score summaries, or inference notes)-

(1) Are released only to persons who are qualified to interpret and use them properly. Such release must be closely supervised by a qualified psychologist.

(2) Are subject to access and disclosure procedures of AR 340-21 and AR 40-66, if a patient or client requests copies of documents that result from psychological testing. Decisions of release, access, and inter-professional transmittal will include-

(*a*) The judgment of adverse affects on the individual's mental health.

(*b*) The disposition advice of the senior qualified psychologist.

(3) Are to be reported in official medical records or administrative or legal correspondence only with technical guidance, review, and approval of a qualified psychologist.

(4) Are maintained and disposed of according to AR 25-400-2. When, and if, documents (acquired raw test data, test scores, user aid documents) are found in ITRs, OTRs, HRECs, consultation service case files, or photograph and duplicate medical files (file number 40-66y), they should be removed and given to the psychology organizational element for proper filing in the clinical psychology individual case file.

c. Reports of psychological test evaluation or assessment (that is, written statements of test data analyses to include summaries, interpretations, diagnostic formulations, dispositions, and consultation request responses) will conform to the requirements of paragraphs 12-3*b* and *c*. Requests for release and disclosure of psychological testing evaluation reports will be processed according to AR 40-66 and AR 340-21. Refer to paragraph *b*(2) above for requests from patients.

d. According to AR 40-66, a review of clinical psychology entries in medical records (that is, ITRs, OTRs, and HRECs) will be an integral part of the 'documentation review' activity in the IOP structure.

12-5. Qualifications of occupations/specialties in psychological testing

The following is a list of qualification guidelines for personnel who are typically involved in the use (administration, scoring, interpretation, and reporting) of psychological tests:

a. Military, DA, and Government contract civilian psychologists who are eligible candidates for full professional responsibility in psychological testing include-

(1) Military officer personnel possessing the specialty skill identifier of psychologists, Medical Functional Area 73B67.

(2) DA and Government contract personnel who function in, and have been appraised as qualifying to perform psychological evaluations in positions of-

(a) Clinical psychologist (series 180, GS-11 and above).

(b) Counseling psychologist (series 180, GS-11 and above).

b. Military officer and civilian personnel who are in training under the Clinical Psychology Internship Program may be involved.

c. DA or Government contract civilian personnel who function in psychologist positions (series 180, GS-09) and who qualify, may be involved in the testing activities in (1) through (3) below only in consultation with a psychologist supervisor having professional accountability responsibilities. These personnel may-

(1) Administer and score psychological tests.

(2) Make preliminary interpretations of the validity and significance of test data.

(3) Evaluate overall patterns revealed by some psychological tests.

d. The military and civilian personnel in (1) and (2) below may be used for psychological test administration and scoring only under the supervision of a qualified psychologist. These individuals are not permitted to make test interpretations or accomplish other test usage activities.

(1) Military enlisted personnel awarded the MOS of mental health technician (91X).

(2) DA civilian personnel who qualify to function in psychology aid positions (series 181, GS-04) or psychology technician positions (series 181, GS-05 through GS-09).

Chapter 13

Emergency Medical Services

13-1. Applicability

This chapter establishes policy, prescribes procedures, and assigns responsibilities for the administration and management of emergency medical services (EMS) in non-deployed Army MTFs. This includes MTFs with inpatient capabilities as well as facilities that provide emergency ambulance services and advertise the provision of emergency care. Deployed MTFs set up on or near hospital grounds for training purposes are also subject to this regulation. Medical units deployed off post will meet these standards to the best of their ability in line with their overall mission. Policies also apply to U.S. Army (AD and RC) and civilian (civil services, foreign national hire, and contract) health care providers.

13-2. Scope

Policies cover all aspects of EMS including those provided in both the prehospital and hospital settings. Policies do not address off-site deployed facilities.

13-3. Policy

a. EMS patients.

(1) Any eligible beneficiary with a stated or apparent patient care emergency arriving at an MTF shall be evaluated, treated, and/or referred. It shall be the responsibility of a designated EMS health care provider or the medical commander's designated representative to determine which patients have a patient care emergency and to refer the patient to the appropriate resources for care. If referral to another MTF (military or civilian) is necessary, the patient shall be evaluated by the most appropriate senior and experienced provider and stabilized before transfer. If a physician is not available then the most senior and experienced authorized medical individual will make transfer decisions.

(2) Patients who are ineligible for military health care services, but come to an MTF seeking emergency care shall be evaluated by a provider and shall be treated as appropriate if the provider determines that a patient care emergency exists. Referral or transport to an appropriate civilian treatment facility shall follow the written guidelines for transport and referral after appropriate provider evaluation.

(3) All MTFs shall, during routine hours of operation, have the capability to determine if a patient care emergency exists and to initiate life and limb saving measures before providing definitive treatment or transporting the patient for definitive treatment.

(4) When a facility is not open for care, arrangements shall be made to provide emergency assistance utilizing military or civilian resources. Such arrangements shall provide an EMS level of care that meets or exceeds community standards and is consistent with the facility's mission, patient requirements, and medical assets.

b. EMS level capability.

(1) The MTF commander will designate EMS capability at level I, II, III according to paragraphs (2), (3), and (4) below. Each MTF shall be responsive to the health care needs of the population served but the designated EMS level

shall not exceed the personnel and equipment resources of the MTF. When the needs of a patient exceed the capability of available resources, then the patient should be referred to the closest appropriate facility.

(2) Level I emergency department/service-

(a) Offers comprehensive emergency care 24 hours a day with at least one physician experienced in emergency care on duty in the EC area.

(b) Has in-hospital physician coverage by members of the medical staff or by senior-level residents.

(c) Has specialty consultation available in the facility within approximately 30 minutes; initial consultation through two-way voice communication is acceptable.

(3) Level II emergency department/service offers emergency care 24 hours a day, with at least one physician experienced in emergency care on duty in the EC area, and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents.

(4) Level III emergency department/service offers emergency care 24 hours a day, with at least one physician available in the EC. Specialty consultants for admission or referral must be available within a reasonable time. Procedures for transfer of stabilized patients must be prearranged and available.

(5) A facility that does not meet levels I through III should not be classified as an emergency facility and should not advertise itself as providing any level of emergency medical care. An MTF that does not provide 24 hour/day in-house EMS shall not use the word 'emergency' to advertise its medical service capability. Signs indicating an EC or EMS capability shall be restricted to those MTFs that offer EMS 24 hours/day.

(6) Facilities categorized at appropriate levels must have appropriately trained and certified staff, equipment, and supplies consistent with the national standard of the specialty of emergency medicine and contingency arrangements for practically dealing with unexpected situations (such as mass casualties and disaster preparedness).

c. EMS providers.

(1) The Chief, EMS and the EMS staff physicians will fulfill the experience, training, and certification requirements as defined in tables 13-1 and 13-2.

(2) Clinical privileges granted to health care providers for EMS practice shall be based on specific education, training, and experience requirements as stated in AR 40-48 and AR 40-68. The EMS clinical privileges for EMS health care providers shall define those patient care activities and procedures that providers can perform independently, those requiring consultation or supervision, and, as appropriate, those that cannot be provided. Experience and training requirements for civilian or contract physicians employed as EMS staff shall be the same as AD military EMS physicians.

(3) The EMS facility shall be staffed with EMS health care providers who have current life support training according to specified levels of this regulation. All EMS health care personnel must have current basic life support (BLS) or be specifically exempted for appropriate reasons (for example, current Advanced Cardiac Life Support (ACLS) certification) by the supervising physician. PAs, nurse practitioners (NPs), and emergency nurses shall have as a minimum, current ACLS training. All non-physician EMS providers practicing without immediate physician supervision must also have current Advanced Trauma Life Support (ATLS) and Pediatric Advanced Life Support (PALS)/Advanced Pediatric Life Support (APLS) certification.

(4) Training of emergency medical technician (EMT) personnel shall be according to the Department of Transportation EMT National Standard Curriculum or equivalent to it and accepted by the National Registry for Emergency Medical Technicians (NREMT). EMTs working in prehospital EMS, to include both ground and air ambulance, shall possess and maintain current certification through the NREMT commensurate with the requirements of the positions to which currently assigned (that is, emergency medical technician-basic (EMT-B), emergency medical technician-intermediate (EMT-I), emergency medical technician-paramedic (EMT-P)). Newly appointed civilian EMTs who are not NREMT-certified must, as a minimum, possess EMT certification from the state in which the employing MTF is located and any neighboring state(s) in which emergency responses are required. These employees, who do not have the NREMT certification, shall be given up to 1 year to obtain national certification. There must be a process for monitoring NREMT status and validating that the NREMT certification remains current.

(5) Clinical privileges for providing patient care in an EC shall be granted to appropriately qualified physicians, dentists, psychologists, social workers, NPs, and PAs. Physician supervision and accountability shall be required when NPs and PAs are diagnosing and treating patients in an EC. Physician supervision, responsibility, and accountability are also required when EMT personnel are treating patients at the scene of an emergency, during emergency transport, or in the EC. Supervision of EMT personnel treating patients at the scene of an emergency, or en route, may be by two-way voice communications. EMT personnel shall provide treatment only according to guidelines approved by the EMS physician supervisor who will be assigned oversight responsibility for all phases of prehospital care and standards.

(6) NPs, PAs, emergency nurses, EMTs, and other health care personnel may be used to augment physician services when appropriately privileged or certified and supervised. The records of emergency patients treated by NPs, PAs, and general medical officers providing care in the EC will be reviewed within a locally defined acceptable time of the treatment.

(7) All health care personnel shall receive orientation training (including current BLS) before assignment in the

EMS. Specific training in utilization of ambulance attendants in the EC, dispatch, medical control, EMT protocols, and IOP activities are encouraged.

(8) In a level I, II or III EMS facility using NPs or PAs, the EMS physician shall be present in the EC with the alternative providers. If the physician supervisor must leave the area for brief periods of time, he or she must be immediately available by two-way communications and be physically present in the hospital.

(9) When technical staff (91B, 91C, EMT) are utilized within the EC, their duties will be defined in writing. Supervision will be the responsibility of the EMS physician or charge nurse, as appropriate.

d. Physician referral. Any patient having a problem beyond the scope of the NP's or PA's clinical privileges or clinical judgment shall be referred to an EMS physician. Common sense and good judgment should be used for referral of patients to supervising physicians by non-physician providers. Local guidelines should be developed for types of patients requiring physician referral. Examples of patients that may need referral include but are not limited to-

- (1) Any patient having a life threatening problem.
- (2) Any patient requesting to see a physician.
- (3) Any patient having a major trauma multi-system injury.
- (4) Any patient having an unscheduled repeat visit within 72 hours for the same complaint or returning more than twice for an acute problem over a 1 month time period.
- (5) When the NP or PA determines the need for referral.
- (6) When patient transport or referral to another facility is necessary.

e. Prehospital emergency services.

(1) Prehospital EMT services must be defined by the MTF commander as EMT-B, EMT-I, or EMT-P. Such services must be mission focused and meet the requirements of this regulation.

(2) Two health care personnel shall accompany each ground ambulance when dispatched on an emergency. A minimum of one health care staff member shall accompany each air ambulance when dispatched on an emergency. This may include any combination of qualified health care personnel who can provide for the emergency care of the patient. If the health care personnel are non-physicians or do not have clinical privileges to provide emergency patient care, these individuals shall be under the direction of an EMS physician. All treatment during ambulance or helicopter transport-other than that rendered by an EMS physician-shall be in accordance with guidelines approved by the EMS physician supervisor. (Health care for a patient should not be passed from a more experienced or higher level of care to a less experienced or lower level of care unless specifically approved by a responsible supervising physician who is accepting responsibility for the transfer.)

(3) All treatment in the prehospital setting shall be appropriately documented at the scene, during transport, and finalized at the termination of the prehospital mission (for inclusion in the patient's ITR, HREC, or OTR) according to the highest recognized local and national standards for EMS. A designated EMS physician supervisor shall review all care provided by health care personnel during ambulance or helicopter transport.

(4) Each EMS will meet State and Federal requirements for ambulance vehicles and other emergency medical support equipment unless specifically excluded for valid medical reasons by the responsible supervising EMS physician staff.

f. Written diagnostic and treatment guidelines.

(1) Written diagnostic and treatment guidelines for initial patient care in ECs shall be available in each EMS. Guidelines shall be developed or adopted and utilized to reflect nationally standardized guidelines or the equivalent. Guidelines may be supplemented locally but shall be concise and convey the essential diagnostic and therapeutic measures that may be rendered quickly by EMS health care providers whose primary expertise may not be emergency medicine.

(2) Written diagnostic and treatment guidelines will be provided as aids for augmenting clinical judgment in prehospital patient care and to help avoid errors of omission. These guidelines should be developed and modified according to local resources and logical acceptable standards. Flow chart or checklist-type guidelines in prehospital EMS also serve as educational aids and provide a quick review for EMS health care providers. EMS health care providers may responsibly deviate from established guidelines when clinical judgment so dictates, but such deviations should not exceed a provider's scope of practice.

g. Performance improvement. The EMS will actively participate in organizational IOP activities as described in the MTF program. Occurrence screens specific to the EMS shall be a part of the EMS IOP process.

h. Patient transfer. A written plan shall exist at each MTF for transporting or referring emergency patients for definitive treatment. The plan shall establish responsibility for the patient during transfer and set forth procedures for conveying pertinent patient care documents, which shall accompany the patient being transferred. The patient shall be transferred only on order of the physician in charge (or designated representative) and after a physician at the receiving hospital has consented to accept the patient.

i. Community agreements. MTFs, as appropriate, will initiate written working agreements with the surrounding civilian MTFs. The working agreements shall specify the requirements for prehospital response, patient referral and transfer, mutual support disaster plans, and the means of communication among facilities. EMS standards shall meet or exceed surrounding community standards.

Table 13–1
Chief, emergency medical services—experience, training, and certification requirements

EMS level: Level I

Requirements: Successfully completed an accredited emergency medicine residency and applied for or successfully completed board certification in emergency medicine.

EMS level: Level II

Requirements: Successfully completed an accredited emergency medicine residency or a primary care residency with 2 years experience working in EMS within the last 5 years, and current certifications in ATLS, ACLS, and PALS/APLS.

EMS level: Level III

Requirements: Successfully completed an accredited emergency medicine residency or a primary care residency and with 6 months clinical experience in emergency medicine in the past 2 years with current ACLS, ATLS, and PALS/APLS certification.

Table 13–2
Emergency medical services staff physicians—experience, training, and certification requirements

EMS level: Level 1

Requirements: There will be at least one full-time physician physically present in the EC 24 hours/day who successfully completed an accredited emergency medicine residency or is residency trained or board certified in a primary care specialty with current experience in emergency medicine and current ATLS, ACLS, and PALS/APLS certification.

EMS level: Level II

Requirements: There will be at least one full-time physician physically present in the EC 24 hours/day who meets the same requirements as for Level I.

EMS level: Level III

Requirements: There will be at least one full-time physician physically present in the EC 24 hours/day who meets the same requirements as for Level I or Level II or is residency trained in any clinical specialty and has extensive current emergency medicine experience (working more than 20 hours per week for the past 12 months) in similar or higher level emergency care institutions, and is currently certified in ACLS, ATLS, and PALS/APLS.

Chapter 14

Medical Laboratory Management

14–1. General

a. This chapter further defines the implementation of the CLIP within the U.S. Army in accordance with policies and procedures contained in publications published separately.

b. Specific technical standards of CLIP and the minimal conditions that laboratories must meet to be certified to perform testing on human specimens are contained in publications that will be published separately.

14–2. Applicability

This chapter applies to all fixed Army MTFs worldwide that operate a clinical laboratory. (See Glossary, section II.) This chapter applies to AD, Reserve, and National Guard components and to clinical laboratories operated under the executive agency of the U.S. Army (United States Military Entrance Processing Command and the U.S. Army Corps of Engineers). This chapter does not apply to facilities that perform testing only for forensic purposes; research laboratories that test human specimens but do not report patient-specific laboratory results for the diagnosis, prevention, or treatment of any disease, or the assessment of health for individual patients; or laboratories that perform solely drug-of-abuse testing under DODI 1010.1 and AR 600-85.

14–3. Responsibilities

a. The Commander, USAMEDCOM will-

(1) Establish corrective action procedures for clinical laboratory facilities whose proficiency testing or performance criteria fall outside the standards to the Tri-Service CLIP regulations.

(2) Establish standards and promulgate policy for implementation of quality clinical laboratory testing within all units assigned to the USAMEDCOM.

b. RMC commanders will-

(1) Provide medical laboratory, blood bank, and pathology staff assistance visits and technical consultation to

subordinate hospitals, occupational and health clinic laboratories, decentralized laboratories, blood donor centers, and departments of pathology throughout their region.

(2) Appoint regional laboratory consultant(s) to provide oversight of proficiency testing and technical consultation throughout the region concerning laboratory standards, laboratory accreditation, and laboratory business practices. Personnel should be appointed as regional consultants for the following specialties: RMC pathology consultant (board-certified pathologist), RMC laboratory consultant (laboratory manager-71E), RMC chemistry consultant (clinical chemist-71B), RMC microbiology consultant (microbiologist-71A), RMC blood bank consultant (71E8T or 61U), and RMC senior enlisted laboratory consultant (MOS 91K40/50).

(3) Analyze utilization of laboratory resources and assess laboratory performance indicators throughout the RMC region. Develop regional laboratory business plans that optimize use of laboratory resources, consolidate commercial reference laboratory testing contracts, and regionalize the purchase or lease of laboratory reagents or equipment.

(4) Ensure maximum utilization of blood resources within the RMC region by ensuring that blood and blood product inventories are kept at an acceptable medically indicated level, and cross-leveled throughout the region, as appropriate, to reduce outdated and wastage of a valuable resource.

(5) Support the laboratory readiness requirements of the Total Force throughout the RMC. Coordinate and take an active role in ensuring that readiness blood quotas for the ASWBPLs are met as directed from the USAMEDCOM. Coordinate laboratory-related professional filler system/medical filler system and individual mobilization augmentee training of personnel in the region.

(6) Assign qualified pathologists to act as a consultant, and, as required, the laboratory director of all medical laboratories in the region without director-qualified assigned medical personnel, or director-qualified civilian contract personnel.

(7) Provide technical expertise and guidance, on-site monitoring as necessary, and reference laboratory support for laboratories in the region that fail regulatory laboratory proficiency testing. Under a plan of corrective action, approve the decision to resume patient testing for failed analytes or subspecialties in all medical laboratories located within the region.

c. The MTF commander is responsible for the operation and CLIP registration of all medical laboratories within the MTF and all assigned clinics. CLIP registration is accomplished in accordance with guidance published separately.

(1) This includes centralized laboratories, such as the Department of Pathology, but also includes all decentralized medical laboratories including all places in the facility where medical laboratory tests are performed. Examples of common decentralized medical laboratories in MTFs include the following: medical laboratory tests performed in the intensive care unit, critical care unit, EC, or other medical clinics, such as the physical examination clinic, or the occupational health clinic; in vitro medical laboratory tests performed by respiratory therapy or nuclear medicine; medical laboratory tests performed by ancillary staff on patient wards; and medical laboratory tests performed by preventive medicine personnel as part of medical screening programs or health fairs.

(2) The MTF commander determines the requirement and operational need for each decentralized laboratory assigned to the organization and is required to register all medical laboratories (minimal, moderate, or high complexity laboratories, or provider-performed microscopy (PPM) laboratories) with the CLIP office.

d. The Chief, Laboratory Services or Chief, Department of Pathology, depending upon the local designation, is charged with the duties of laboratory director as defined by the CLIP. The chief and his or her staff are responsible for providing quality medical laboratory services throughout the organization, keeping abreast of new or modern developments in the medical laboratory field, and for operating the MTF medical laboratories in compliance with Federal laws, accreditation standards defined by JCAHO, the College of American Pathologists (CAP), the CLIP, and standards of practice within the community. In doing so, the chief will be responsible for-

(1) Assisting and advising health care providers on the cost-effective use of timely, quality medical laboratory services to aid in the medical screening, prevention, and diagnosis or treatment of disease, including monitoring of therapy.

(2) Conducting and documenting inspections and assistance visits for all medical laboratories within the MTF, including medical laboratories in all outlying clinics assigned to the MTF and all troop medical clinics supported by the MTF. Recurring problems and trends not corrected by department or service chiefs will be referred to the appropriate person/group within the MTF's specific IOP structure.

(3) Maintaining adequate reference material (books, periodicals, atlases, computer-assisted instructional material, etc.) and knowledge-based information systems for use by laboratory personnel and other professional staff served by the laboratory.

(4) Providing technical expertise and guidance, on-site monitoring as necessary, and centralized laboratory support for MTF laboratories that fail regulatory laboratory proficiency testing. Under a plan of corrective action, approve the decision to resume patient testing for failed analytes or subspecialties in MTF medical laboratories.

(5) Disseminating information to the professional staff concerning advances in laboratory medicine, use of the laboratory services, laboratory input to clinical practice guidelines adopted by the MTF, and related matters. Appropriate media (for example, CHCS, electronic mail, memorandums, etc.) will be utilized to disseminate information concerning laboratory services available, acceptable specimen requirements, methods of obtaining service, the cost of

each laboratory test ordered, the reference ranges for all laboratory tests provided, and items of interest to the medical staff.

(6) Representing the laboratory services on various committees used by the MTF to improve information management, utilization management, and patient outcomes.

(7) Providing an adequate number of qualified, competent staff to perform the laboratory workload and to provide technical consultation and supervisory duties. The laboratory director also provides for orientation, in-service training, and continuing education for all personnel assigned to the clinical laboratory.

14-4. Accreditation policies

a. All eligible U.S. Army hospital clinical laboratories (Department of Pathology or Laboratory Service) located in fixed MTFs in the United States, Europe, or Korea will be accredited by the Commission on Inspection and Accreditation of the CAP. On-site accreditation inspections are required at least biennially.

b. All fixed MTFs, ambulatory care clinics, and troop medical clinics, including their assigned laboratories, will be accredited by and follow the laboratory guidelines of the JCAHO. The required biennial JCAHO survey of laboratories by a qualified medical technologist inspector will be waived if all laboratories (non-waived testing) assigned to the MTF have been inspected and accredited by CAP.

c. Decentralized laboratories (point-of-care testing, separate health clinics or troop medical clinics, or Military Entrance Processing Stations, etc.) will be inspected biennially and accredited by either CAP, JCAHO, or the Commission on Office Laboratory Accreditation (COLA).

14-5. Laboratory personnel

a. The Chief, Laboratory Service or Chief, Department of Pathology will ensure that only properly qualified personnel whose competency has been assessed will perform and report the results of laboratory testing. Qualifications for testing personnel will be based on laboratory test complexity (minimal, moderate, or high complexity) and will meet the requirements of Section M of the CLIP.

b. Local, on-site training of military or civilian personnel to perform limited minimal or moderate complexity laboratory testing is permitted. In these cases, prior to analyzing patient specimens and reporting patient results, the personnel must be trained appropriately for the laboratory testing performed with a formal training program, not solely limited to on-the-job training. Documentation of training, skills, and competency assessment for these individuals will be maintained on file either within the laboratory, the MTF QA department, or the nursing education and training department. (Refer to AR 40-48.)

c. PPM, a special subset of moderately complex laboratory analyses, may be performed by privileged physicians, dentists, and mid-level practitioners (PAs, NPs, and certified nurse midwives) according to AR 40-48 when authorized by the MTF commander. In such cases, the PPM lab must be registered with CLIP, approved procedures for PPM tests must be instituted, and personnel authorized to perform PPM must be qualified and competency-assessed.

d. At installations that do not have an assigned pathologist, a qualified licensed physician will be assigned as the director of the laboratory. At inpatient facilities without an assigned pathologist, the commander will ensure that appropriate and timely professional pathology services are available to the staff and patients of the facility.

e. At all MTFs without an assigned civilian or military pathologist or without an equivalent contracted pathologist, the commander of the facility will appoint an appropriate regional military pathologist to the medical staff of the MTF as a consultant.

14-6. Quality control

a. Sound quality control systems in all MTF clinical laboratories, including decentralized laboratories, are essential to providing excellent services. Quality control systems must be designed to ensure medical reliability and timeliness of laboratory data. The goal of quality control is to achieve the most accurate test results and outcomes.

b. Each laboratory must have a written, defined, and approved quality control program that meets the standards of the CLIP and any applicable accrediting body. The quality control system must address pre-analytical, analytical, and post-analytical phases of laboratory testing and results reporting.

c. For the subspecialty of cytopathology, a written quality control program must be in place to measure, assess, and improve quality in cytology addressing the accuracy of both positive and negative findings. Each cytopathology service will be directed by a pathologist or other physician qualified in cytology who will maintain the quality of the service through direct supervision and adequate oversight. Annual statistical reports will be produced by each facility performing cytopathology testing. The reports will be collated by each RMC and forwarded to the Commander, USAMED-COM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, for consolidation for the U.S. Army.

14-7. Monetary collections for laboratory services

The laboratory will not serve as a monetary collection agency for medical laboratory test services. However, laboratory personnel will assist the command's TCP office in billing third party insurers for laboratory tests authorized under the TCP.

14–8. Improving organizational performance

a. A laboratory's performance of important health care functions significantly affects the outcomes of the patients it serves, the costs to achieve these outcomes, and the patient's/customer's perceptions or satisfaction. The goal of IOP is to continuously improve the laboratory services that affect patient health outcomes.

b. The Chief, Laboratory Services will implement a collaborative and interdisciplinary performance improvement process that will demonstrate improvement in laboratory services. This process will be integrated with the MTF IOP structure and documentation will provide evidence of ongoing improvement processes.

c. Data will be collected on important laboratory processes and outcomes, including as a minimum: patient preparation, handling of specimens, communication processes, appropriateness of laboratory tests offered (utilization management), and the needs, expectations, and satisfaction of patients and other customers. Data on important processes and outcomes are also collected from risk management and quality control activities.

d. Data will be collected and reported through the RMCs to the Commander, USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, for documentation of compliance with laboratory-related DOD Access Standards. Cervical cytological smear (Papanicolaou smear) screening results should be available to the patient within 14 days of specimen collection, except for isolated branch clinics and overseas locations where results shall be provided within 30 days.

14–9. Individuals authorized to order laboratory tests

a. The following categories of personnel are authorized to order laboratory tests:

(1) Uniformed and civilian physicians, dentists, veterinarians, optometrists, and podiatrists engaged in professional practice at uniformed services MTFs.

(2) Civilian physicians, dentists, optometrists, and podiatrists, not assigned to a uniformed services MTF, but licensed in the jurisdiction of their practice and treating personnel eligible for care within the MHS.

b. The following personnel are authorized to order medical laboratory tests only for selected procedures as established under the provisions of AR 40-48 and/or approved by the local commander:

(1) Uniformed and civilian nurses, PAs, NPs, PTs, OTs, psychologists, and pharmacists engaged in professional practice at uniformed services MTFs and privileged to order medical laboratory tests.

(2) Civilian personnel, not assigned to a uniformed service MTF, but licensed within the jurisdiction of their practice and treating personnel eligible for care in the MHS, to the extent authorized by State law and by policies for equivalent staff non-physician health care providers.

(3) Other non-physician health care providers not listed above, but assigned to a uniformed service MTF and granted limited medical laboratory test ordering privileges by the local commander.

c. Requests for medical laboratory tests written by licensed civilian practitioners not assigned to a uniform services MTF for personnel eligible for care in the MHS, will be honored at Army MTFs according to AR 40-400 subject to the availability of space, facilities, the capabilities of the professional staff, and the following considerations.

(1) A policy relative to performing and reporting laboratory tests ordered by civilian practitioners will be established and announced by the local commander. This policy should coincide with policies regulating staff ordering of laboratory tests and must also include policies concerning the reporting of emergency or alert (panic) value laboratory results to civilian practitioners.

(2) Performance of a laboratory test requested by a civilian practitioner does not imply knowledge of or responsibility for a patient's medical condition. Under no circumstances will civilian laboratory test requests be countersigned or rewritten by military practitioners.

(3) A distance factor or geographic boundary limitation will not be the basis for denying laboratory testing services. MTFs may accept orders for laboratory tests electronically or in writing from civilian practitioners outside the MTF. Verbal orders should not be accepted from civilian practitioners outside the MTF.

(4) Orders for laboratory tests written by foreign licensed practitioners and brought into MTFs located within the United States may be honored in accordance with appropriate State law. In MTFs located outside the United States, the laws of the foreign country and the terms of the applicable treaty and/or administrative or Status of Forces Agreement between the United States and the foreign country concerned will be followed.

(5) Electronic transmittal of laboratory results, including patient identification data, is authorized utilizing direct modem communications without encryption to civilian practitioners. The Internet will not be used for transmittal of unencrypted laboratory results or patient demographic data which is subject to the Privacy Act.

14–10. Self-performance of laboratory tests

a. Patients should not be required to self-perform laboratory tests within the MTF. When current medical practice indicates that a patient may routinely monitor their condition or treatment using an FDA-approved laboratory test for home use, health care providers assigned to the MTF may train the patients on the use and interpretation of the FDA-approved home laboratory test.

b. Laboratory tests performed within the MTF will be performed only by qualified personnel. The results of all laboratory tests performed in the MTF will be entered in the appropriate patient record according to AR 40-66.

14-11. Inspection and disposition of laboratory files and records

a. *Inspection.* Laboratory files and records will be subject to inspection by inspectors (accreditation organizations, other Government entities, and the CLIP) and higher echelon commanders at all times.

b. *Disposition.* Laboratory files, testing results, and other records maintained by the laboratory will be retained and disposed of according to AR 25-400-2. Any alternative method of storage and disposal must be approved by the MTF's records management officer.

Chapter 15 Veterinary Care

15-1. General

This chapter provides guidance for the delivery of veterinary medical care within the United States Army. AR 40-905/SECNAVINST 6401.A/AFI 48-135 addresses veterinary responsibilities and functions to all DOD agencies and the services. The veterinary commander is responsible for delivery of effective and efficient veterinary care. Veterinary medical care provided will be consistent with accepted professional standards.

15-2. Veterinary services

The United States Army Veterinary Corps, as DOD Executive Agent for veterinary services, provides veterinary services to all branches of the DOD. Veterinary services include, but are not limited to-

- a. Veterinary medical care for GOAs.
- b. Control of zoonotic diseases.
- c. Food safety and QA programs.
- d. Veterinary medical care for POAs.

15-3. Authorization of care

The senior area veterinarian will establish the extent and priority to which veterinary medical care is provided to GOAs and POAs within the area of the veterinary commander's scope of responsibility.

15-4. Provision of veterinary medical care

Veterinary commanders will determine how best to employ available resources to provide authorized veterinary medical care taking into consideration the following factors:

a. *Animal categories.* The population and health needs of the different categories of animals provided veterinary care-

- (1) Military working dogs (MWDs), military working horses (MWHs), and GOA and POA health assistance animals (seeing-eye dog, etc.).
- (2) Nonappropriated fund (NAF) animals (rental horses, etc.).
- (3) Unit mascots authorized by appropriate orders (one per company-sized unit).
- (4) Non commercial POAs for authorized care.
- (5) Other GOAs in confinement (buffalo, deer, strays, etc.).
- (6) Free ranging wild/feral animals (game animals, horses, etc.).

b. *Acuteness of the condition.* The presentation of any animal with an acute, life-threatening condition has the highest priority for care. The provision of all other veterinary care is left to the professional judgment of the attending veterinarian consistent with the use of available resources and other factors as determined by the veterinary commander.

c. *Civilian veterinary care for MWDs and MWHs.* In certain circumstances, a military or NAF veterinarian may not be available to provide needed care for a GOA. In these cases, AR 40-330 provides for payment of civilian veterinary care if the following circumstances are met.

- (1) The care is authorized by AR 40-1.
- (2) The care needed is for an emergency or is requested at a time when an Army/NAF veterinarian is not available. The caretaker of the animal needing the care must have permission to utilize a civilian veterinarian. This permission can be obtained by-

(a) Calling the responsible military veterinarian or a delegated animal technician. This necessitates providing all veterinary customers with current emergency telephone/pager numbers and being available to answer calls.

(b) Using a roster of participating local veterinarians that has been previously distributed by the responsible military veterinarian who has specifically noted when he or she will not be available.

(3) Prior written agreements with one or more local civilian veterinarians to accept these types of cases at the time of need with charges being at or below their normal rate of reimbursement for services and supplies.

d. Impact on the Army's mission effectiveness. Potential areas of concern are as follows:

(1) Deployability of MWDs being assigned or likely to be assigned to combat, humanitarian relief, or other areas of intense Army concern.

(2) POAs likely to be moved because of military actions, political unrest, or natural catastrophes such as noncombatant evacuation operations.

(3) POAs belonging to Army personnel assigned to isolated areas where veterinary care is not available from civilian sources.

(4) Disease status of indigenous feral and wildlife and local POAs, for example, an outbreak of rabies, leptospirosis, Lyme disease, or other major zoonotic disease could influence military plans.

15-5. Veterinary training assistance team

a. Purpose. The veterinary training assistance team (VTAT) will perform onsite technical demonstrations and training on veterinary preventive medicine, clinical veterinary medicine, and food safety and QA. VTAT visits may be performed as a cost effective training measure or when such training cannot be obtained practically through other means.

b. Staffing. The AMEDD C&S will form VTATs in coordination with veterinary unit commanders and senior staff elements of major commands. Staff personnel to form a VTAT may come from the following sources:

(1) AMEDD C&S.

(2) U.S. Army Veterinary Command.

(3) Other DOD agencies.

(4) Other qualified persons.

c. Availability. The VTAT is available on request to veterinary unit commanders (TOE or TDA), major overseas commanders, and commanders of military advisory groups or teams. Commanders wanting the help of a VTAT should send a written request to the Commander, AMEDD C&S (MCCS-HV), 2250 Stanley Road, Fort Sam Houston, TX 78234-6100. The requesting commander will ensure all requests are coordinated in accordance with their command policy. The AMEDD C&S will coordinate time and location of training with requesting agency.

d. Funding. The VTAT may be funded by the AMEDD C&S, the requesting commander, or a combination of sources subject to availability of funds.

Appendix A References

Section I

Required Publications

AR 10–64/OPNAVINST 6700.2/AFR 160–29/MCO 5420.18A

Joint Field Operating Agencies of the Office of the Surgeon General of the Army. (Cited in paras 5-2a(1) and 7-2.)

AR 11–2

Internal Management Control. (Cited in para 8-4a(5).)

AR 25–51

Official Mail and Distribution Management. (Cited in para 7-5n(4)(a).)

AR 25–400–2

The Modern Army Recordkeeping System (MARKS). (Cited in paras 11-23b, 12-4b(4), 14-11b, and B-10e(6), B-11a(3), and B-11b.)

AR 30–1

The Army Food Service Program. (Cited in para 8-1.)

AR 30–21

The Army Field Feeding System. (Cited in paras 8-1 and 8-11d.)

AR 40–5

Preventive Medicine. (Cited in para 3-5b(2).)

AR 40–7

Use of Investigational Drugs and Devices in Humans and the Use of Schedule I Controlled Drug Substances. (Cited in para 11-2b(7).)

AR 40–21

Medical Aspects of Army Aircraft Accident Investigations. (Cited in para 3-6f(3).)

AR 40–25/NAVMEDCOMINST 10110.1/AFR 160–95

Nutritional Allowances, Standards and Education. (Cited in para 8-10.)

AR 40–38

Clinical Investigation Program. (Cited in para 11-24.)

AR 40–48

Nonphysician Health Care Providers. (Cited in paras 3-3, 8-4a(3), 11-10b, 13-3c(2), 14-5b, 14-5c, and 14-9b.)

AR 40–61

Medical Logistics Policies and Procedures. (Cited in paras 11-22a, B-2, B-3b, B-9b, and B-10c(4).)

AR 40–66

Medical Record Administration and Health Care Documentation. (Cited in paras 2-4a(2), 6-5, 8-9e, 8-17a, 10-5c, 12-4b(2), 12-4c, and 12-4d.)

AR 40–68

Quality Assurance Administration. (Cited in paras 8-4a(3), 8-4b(4), 11-8b(3), 12-3i, and 14-3c(2).)

AR 40–400

Patient Administration. (Cited in paras 6-1, 6-3c, 9-1d(6), 10-3, 14-9c, and 14-10b.)

AR 40–501

Standards of Medical Fitness. (Cited in paras 3-2f(2), 3-5c(1), 3-8a, 4-1a(2), 4-2a, and 6-4a(3).)

AR 40-905/SECNAVINST 6401.A/AFI 48-135
Veterinary Health Services. (Cited in para 15-1.)

AR 95-1
Flight Regulations. (Cited in para 3-6f(6).)

AR 190-13
Hazardous Biological Substances in Army Research, Development, Test, and Evaluation Facilities. (Cited in para B-4c.)

AR 190-40
Serious Incident Report. (Cited in para B-4c.)

AR 190-51
Security of Unclassified Army Property (Sensitive and Nonsensitive). (Cited in para B-4a.)

AR 340-21
The Army Privacy Program. (Cited in paras 12-4b(2) and 12-4c.)

AR 385-95
Army Aviation Accident Prevention. (Cited in paras 3-5b(1), 3-5b(2), 3-6, 3-6b(6), 3-6e(1), 3-6f(3), and 3-7.)

AR 600-9
The Army Body Composition Program (formerly The Army Weight Control Program). (Cited in para 8-9i.)

AR 600-85
Alcohol and Drug Abuse Prevention and Control Program. (Cited in para 14-2.)

AR 600-105
Aviation Service of Rated Army Officers. (Cited in paras 3-6e(1), 3-6f(6), and 3-7a.)

AR 600-8-1
Army Casualty Operations/Assistance/Insurance. (Cited in para 9-1d(4).)

AR 611-101
Commissioned Officer Classification System. (Cited in para 8-4a(4).)

AR 700-84
Issue and Sale of Personal Clothing. (Cited in paras 10-2 and 10-5c.)

AR 710-2
Supply Policy Below the Wholesale Level. (Cited in paras 8-18b and 10-5c.)

AR 735-17
Accounting for Library Materials. (Cited in paras 7-6b, 7-9, C-6c(3), and C-6c(4).)

DA PAM 385-40
Army Accident Investigation and Reporting. (Cited in para 3-6e(1).)

DA PAM 611-21
Military Occupational Classification and Structure. (Cited in para 8-4a(4).)

FM 3-04.301
(Formerly FM 1-301) Aeromedical Training for Flight Personnel. (Cited in para 3-6c.)

FM 8-505
Army Medical Field Feeding Operations. (Cited in para 8-1.)

TB MED 250
Recording Dental Examinations, Diagnoses, and Treatments. (Cited in para 6-4a(5).)

TB MED 530

Occupational and Environmental Health Food Service Sanitation. (Cited in paras 8-4b(2) and 8-12a.)

Unnumbered publication

FAA Guide for Aviation Medical Examiners. (Cited in paras 3-9b(1), 3-9d, and 3-9f(1).) (This publication is available from the Department of Transportation, FAA Office of Aviation Medicine, Washington, DC 20591.)

Unnumbered publication

The Joint Commission on Accreditation of Healthcare Organizations Accreditation Manual for Hospitals. (Cited in paras 5-3k(5), 7-5c, 7-5x, 8-4b(2), 8-7a, 8-12a, 11-2b, 11-25a, 14-3h, 14-4b, and 14-4c.) (This publication may be obtained from JCAHO, 875 N. Michigan Ave., Chicago, IL 60611.)

P.L. 94-553

Copyright Law. (Cited in para 7-5n(7).)

Section II**Related Publications**

A related publication is a source of additional information. The user does not have to read it to understand this regulation.

AR 1-100

Gifts and Donations

AR 30-18

Army Troop Issue Subsistence Activity Operating Procedures

AR 30-19

Army Commissary Store Operating Policies

AR 40-1

Composition, Mission, and Functions of the Army Medical Department

AR 40-8

Temporary Flying Restrictions Due to Exogenous Factors

AR 40-35

Preventive Dentistry

AR 40-330

Rate Codes, Expense and Performance Reporting Systems, Centralized Billing, and Medical Services Accounts

AR 70-65

Management of Controlled Substances, Ethyl Alcohol, and Hazardous Biological Substances in Army Research, Development, Test, and Evaluation Facilities

AR 215-1

Administration of Army Morale, Welfare, and Recreation Activities and Nonappropriated Fund Instrumentalities

AR 600-20

Army Command Policy

AR 635-40

Physical Evaluation for Retention, Retirement or Separation

ASD(HA) Memorandum dated 31 May 1990

Subject, Schedule II Controlled Substances Waiver for Electronic Approval and letter, Drug Enforcement Administration, dated 26 Mar 1990. (Copies of the memorandum and letter may be obtained from Commander, USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.)

CMH Pub 83-3

NATO Handbook of Emergency War Surgery

DFAS-IN Manual 37-100-FY

The Army Management Structure

DOD 1338.10-M

Manual for the Department of Defense Food Service Program

DOD 7000.14-R, Volume 12

DOD Financial Management Regulation, Volume 12: Special Accounts, Funds and Programs

DOD Directive 6000.12

Health Services Operations and Readiness

DOD Instruction 1010.1

Military Personnel Drug Abuse Testing Program

DOD Instruction 6480.4

Armed Services Blood Program Operational Procedures

FM 8-70/NAVMED P-5120/AFMAN 41-111

Standard for Blood Banks and Transfusion Services

SB 8-75 series

Army Medical Department Supply Information

TM 8-227-3/NAVMED P-5101/AFMAN 41-119

The Technical Manual of the American Association of Blood Banks

U.S. Department of Transportation, Emergency Medical Technician-Basic: National Standard Curriculum

Current edition. (Curriculum may be ordered from Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954 or by call

Ethical Principles of Psychologists

Washington, DC: American Psychological Association, 1992. (Copies of American Psychological Association publications may be ordered from: American Psychological Association, Book Order Department, Dept KK, P.O. Box 92984, Washington, DC 20090-2984.)

Specialty guidelines for the delivery of services by clinical, counseling, industrial/organizational, and school psychologists

Washington, DC: American Psychological Association, 1981. (See address above.)

Standards for Educational and Psychological Testing

Washington, DC: American Psychological Association, 1995. (See address above.)

RCS MED-402

U.S. Army Medical Command Library Annual Report FY__.

Section III

Prescribed Forms

DA Form 3862

Controlled Substances Stock Record. (Prescribed in para 11-19 and app B.)

DA Form 3875

Bulk Drug Order. (Prescribed in para 11-12d.)

DA Form 3949

Controlled Substances Record. (Prescribed in para B-5.)

DA Form 3949-1

Controlled Substances Inventory. (Prescribed in para B-5.)

DA Form 3982

Medical and Dental Appointment. (Prescribed in para 6-6e.)

DA Form 7397-R

U.S. Army Medical Command Library Annual Report FY___. (Prescribed in paras 7-4c(6) and 7-8 and app C.)

DD Form 1289

DOD Prescription. (Prescribed in paras 11-12b(1), 11-13b, 11-16, B-7a, and B-8.)

DD Form 2081

New Drug Request. (Prescribed in para 11-6e.)

DD Form 273

Organ and Tissue Donor Card. (Prescribed in paras 9-2b(2) and 9-2c(12).)

Section IV

Referenced Forms

DA Form 11-2-R

Management Control Evaluation Certification Statement

DA Form 1296

Stock Accounting Record

DA Form 2927

Hospital Food Service-Telephone Diet Order

DA Form 3032

Signature Headcount Sheet

DA Form 3078

Personal Clothing Request

DA Form 3158

Statement of MSA Dining Facility Cash Receipts and Meals Served

DA Form 3161

Request for Issue or Turn-In

DA Form 3801

Guest Log for Meals

DA Form 4106

Quality Assurance/Risk Management Document

DA Form 4186

Medical Recommendation for Flying Duty

DA Form 4256

Doctors Orders

DA Form 4700

Medical Record-Supplemental Medical Data

DA Form 5570

Health Questionnaire for Dental Treatment

DD Form 2A (ACT)

Active Duty Military ID Card

DD Form 150

Special Measurements Blank for Special Measurement/Orthopedic Boots and Shoes

DD Form 1348

DOD Single Line Item Requisition System Document (Manual)

DD Form 1348M

DOD Single Line Item Requisition System Document (Mechanical)

DD Form 1556

Request, Authorization, Agreement, Certification of Training and Reimbursement

DD Form 2555

Armed Services Blood Program Blood Bank Operational Report

DD Form 2807-1

Report of Medical History

DD Form 2808

Report of Medical Examination

DOFC Form 10

Fitting Report-Special Footwear. (Copies of this form can be obtained from the Defense Orthopedic Footwear Clinic, 666 Summer St., Boston, MA 02210.)

SF 509

Medical Record-Progress Notes

SF 513

Medical Record-Consultation Sheet

SF 523B

Medical Record-Authorization for Tissue Donation

SF 558

Medical Record-Emergency Care and Treatment

SF 600

Health Record-Chronological Record of Medical Care

SF 603

Health Record-Dental

SF 603A

Health Record-Dental-Continuation

AC Form 8500-33

Medical Forms and Stationary Requisition. (This form may be obtained from the Manager, Aeromedical Education Division, AAM400, 6500 S. MacArthur Boulevard, Oklahoma City, OK 73169.)

FAA Form 8500-8

Application for Airman Medical Certificate or Airman Medical and Student Pilot Certificate. (This form is a controlled item and is distributed by the Federal Aviation Administration.)

Appendix B Inventory, Control, and Accountability of Controlled Substances

B-1. Purpose

The purpose of this appendix is to provide guidance for the accounting, control, and physical security of controlled substances.

B-2. Responsibilities

AR 40-61 provides overall responsibilities for the control of medical items. The following paragraphs delineate additional responsibilities as applicable to pharmaceuticals classified as controlled substances.

a. The Chief, Pharmacy Services or the Director, Department of Pharmacy—depending on the local designation—is responsible for safeguarding and accountability of all controlled substances received, issued, and dispensed by the hospital pharmacy and will—

(1) Maintain a current listing of all activities authorized to receive controlled substances as determined by the P&T Committee.

(2) Conduct periodic controlled medication reviews to detect overuse and/or abuse of controlled drugs. Any significant trends or findings will be reported to the P&T Committee as appropriate.

b. Department and service chiefs are responsible for safeguarding and accounting for all controlled substances issued for use within their activities.

c. Officers-in-charge of patient care areas are responsible for the maintenance of the controlled substances register and will ensure the correct storage of controlled substances under this regulation.

d. The chief of logistics is responsible for the care, preservation, and surveillance of installation stocks of all controlled substances.

e. The inventory officer(s) is responsible to the MTF commander for complying with the instructions contained in this chapter and those otherwise provided.

f. The chiefs of all areas inventoried will scrutinize all findings in their respective areas to detect any significant trend toward increased use of any controlled substances and take immediate action to determine the reasons for increased use.

g. The commanders of medical supply, optical, and maintenance units, and other medical supply operations are responsible for the care, preservation, and surveillance of installation stocks of all controlled substances.

B-3. General policy

a. At least annually, the MSO will request the local provost marshal to evaluate the security of controlled medical items at all medical materiel storage areas to include logistics and the pharmacy. This survey will be documented and installation engineer support will be obtained to accomplish any facility adaptation required for improvement of security.

b. Controlled substances are drugs so designated by the DEA and assigned to one of five schedules according to the abuse potential and degree of control required. A list of controlled substances and changes are published in the Federal Register and in the SB 8-75 series. Any other items designated by the commander to be controlled may be handled either as Schedule II or Schedules III-V with reference to the recordkeeping and physical security requirements according to this regulation and AR 40-61.

c. The Chief, Pharmacy Services or the Director, Department of Pharmacy will ensure that only authorized activities receive controlled substances from the pharmacy. Issue to these activities will be completed by proper entry into the controlled substances register (see para B-5f) of the receiving activity by responsible pharmacy personnel. Criteria for issue to the activity will be based on appropriate medical need and appropriate physical security during both transport and storage.

d. Wards, clinics, and other activities receiving controlled pharmaceuticals will manage them as indicated in this regulation. The use of unit dose packaging of controlled substances will simplify this responsibility in patient care areas. The commercial reverse-numbered unit dose package is considered the package of choice whenever available. Use of automated dispensing equipment that satisfy the intent of this regulation without the manual utilization of controlled substance registers is authorized.

e. Stock levels of controlled substances should not exceed an anticipated 2-week supply for wards or clinics or a 30-day level for each pharmacy section unless otherwise specified by the commander.

f. Controlled substances (unit package or broken lots) will be turned in to the pharmacy when no longer required, as outlined in paragraph B-8.

g. Controlled substances collected from patients will be handled, safeguarded, and accounted for in the same manner as regularly stocked controlled substances. However, returned drugs should be segregated from regular stock to ensure that they are not reissued.

h. A physical inventory will be conducted within the pharmacy on any normal administrative duty day. This inventory will include all controlled substances having an issue or receipt action since the last inventory. All controlled

substances will be inventoried at least weekly, regardless of activity. MTF commanders will ensure that the inventory is conducted weekly and corrective action taken promptly when discrepancies not attributable to operational losses are discovered. Within the guidance established by the local commander, an adjustment for minor overages and shortages caused by operational handling or undiscoverable posting errors will be made by posting an inventory adjustment to the stock record. All adjustments will be given to the monthly inventory team to be included in their report and a copy will go to the security officer.

i. An inventory and audit of all controlled items throughout the facility will be conducted monthly. The medical activity commander will appoint a disinterested officer, a noncommissioned officer (SSG or above), or DA civilian (GS-7 or above) to perform the duty. Commanders or a designee will change inventory officer assignments each month, ensure that the inventory officer(s) receives timely appointing orders, a briefing concerning the importance of this function and responsibilities, a current set of pertinent regulations, a list of activities and controlled substances to be inventoried, and rubber stamps required to accomplish the inventory. Instructions and procedures for conducting the controlled substances inventory are in paragraph B-10.

j. The monthly inventory and audit of controlled substances should be conducted between the first and tenth working day of the month, and a typewritten report submitted to the MTF commander by the 15th working day of the month.

k. This guidance does not apply to clinical research activities. Guidance to account for controlled substances in Army RDTE facilities is addressed in AR 70-65.

B-4. Physical security

a. AR 190-51, chapter 4, establishes policy, procedures, and minimum physical security standards for the storage of controlled medical substances and medically sensitive items.

b. A physical security officer, appointed in writing by the MTF commander, will ensure appropriate protection of all controlled substances and sensitive items.

c. Facility commanders will ensure that an annual physical security inspection is conducted according to AR 190-13. In addition, commanders may request the U.S. Army Criminal Investigation Command to conduct crime prevention surveys for the purpose of detecting crime, evaluating the possibilities of easy criminal activity, and identifying procedures conducive to criminal activity. Theft, loss, recovery, or mismanagement of significant quantities of controlled substances and other medically sensitive items will be reported according to AR 190-40, paragraph C-1d(5).

B-5. Composition and maintenance of the Controlled Substances Register for patient care areas

a. Arrangement of controlled substances register. The controlled substances register will be maintained in a loose-leaf binder. The register will be divided into two major sections, one for Schedule II items and the other for Schedules III-V items. Each of these sections will contain two subsections as follows:

(1) *Active files section.*

(a) *DA Form 3949-1 (Controlled Substances Inventory).* This will be filed in front. A sample of a completed DA Form 3949-1 is at figure B-1.

(b) *DA Form 3949 (Controlled Substances Record).* A sample of a completed DA Form 3949 is at figure B-2.

(2) *Inactive files section.* This includes any DA Form 3949 that has been audited and has a zero balance but may be used at a later date.

b. *Use of forms as the centralized filing method.* The above described sequence of forms will be used as the centralized filing method for records pertaining to receipts, issues, balances, and audits of controlled substances for which appropriate personnel are responsible. Records will be kept in a controlled area of the patient care area and will be available only to authorized personnel.

c. *Preparation of DA Form 3949-1.* A DA Form 3949-1 will be maintained in the controlled substance register for all patient care areas operating multiple shifts. This form will be completed as outlined in paragraph B-6.

d. *Preparation of DA Form 3949.* Separate DA Forms 3949 will be prepared for each controlled substance line item stocked. Forms will be arranged in sequence to correspond with the order in which the drugs are listed on DA Form 3949-1, appropriately marked to denote the controlled substance, and filed behind indexed divider sheets. The box heading of each DA Form 3949 will be completed to reflect the ward number or clinic, date, correct name and strength of the drug to include nomenclature and generic name, accountable unit of measure, and balance on hand. Common trade names such as Demerol^(tm) for meperidine hydrochloride injection may be inserted immediately following the nomenclature for ease of identification of the controlled substance. All entries will be recorded in ink or typewritten.

e. *Controlled substances expenditure entries.*

(1) Each time a controlled substance is administered in a patient care area, complete information will be recorded as to the disposition of the substance. The day, hour, patient's name, initial, and last name of the health care provider who ordered the medication, signature of the individual administering the substance, and the accountable unit of the substance dispensed will be entered. The amount expended will then be subtracted from the amount shown in the 'balance' column and the new balance will be recorded in the 'balance' column. All amounts will be recorded in

Arabic numbers. (Roman Numerals are not acceptable.) In cases where the accountable unit is designated in milliliters (ml), any fractional amount used will be recorded as a decimal fraction.

(2) In cases where the dose administered is a fraction of the accountable unit for the drug, the dose administered will be placed in parentheses before the number of units indicated in the 'expenditure' column. For example, '(10mg) 1' would indicate that one cartridge-needle unit of morphine sulfate injection, 15mg (15 milligrams), had been expended but that only 10mg was administered.

f. Entries in cases of accidental destruction, damage, or contamination. If a dose(s) of a controlled substance is accidentally destroyed, damaged, or contaminated during the preparation for administration, a record of the fact will be made on the DA Form 3949, including the date, amount of the drug, brief statement of the circumstances, the new balance, the signature of the person making the entry, and, when possible, the signature of a second individual for verification.

g. Controlled substances receipt entries. When controlled substances are issued to a patient care area, the pharmacy representative will record on the appropriate DA Form 3949 the following: the day and hour delivered in the columns indicated; the words, 'pharmacy issue' in the 'patient's name' column; the document number in the 'ordered by' column; the amount of the drug issued in the 'receipts' column; and the new balance in the 'balance' column. The pharmacy representative will enter his or her signature in the 'administered by' column. The receiving authorized persons will acknowledge receipt of the drug by placing their initials in the 'expenditures' column on the same line as the entry made by the pharmacy representative. Personnel will then sign the document used to request the drug with their name, grade or rank, SSN, date, hour, and quantity received.

h. Correction of errors. Erasures and eradications invalidate records and such methods will not be used to correct errors in the Register. Errors will be corrected by drawing a single line in ink through the erroneous entry, and adding the initials of the person making the correction and the date the correction was made. The correct entry will be recorded in the same block, adjacent to the erroneous entry. If the entire line is erroneous or the corrected entry can not be placed in the same block, draw a line through the entire entry and date and initial it. Make the correct entry on the next available line.

i. Measuring system for liquid controlled substances. The pharmacy will dispense liquid controlled substances in appropriate oral syringes or unit dose vials with tamper-proof caps whenever possible. Containers should be standardized for ease in inventorying quantities on hand. Some examples would be: morphine elixir, 5 ml; cocaine topical solution, 4 percent, 4 ml; acetaminophen w/codeine elixir, 5 ml.

B-6. Tour-of-duty inventory

a. On all patient care areas operating multiple shifts, transfer of the possession of controlled substances will be effected by making a joint inventory of such items and comparing the amounts on hand with the balances shown on DA Form 3949. At the completion of each tour of duty, the registered nurse, civilian licensed practical nurse, or clinical specialist going off duty and the registered nurse, civilian licensed practical nurse, or clinical specialist coming on duty will perform the inventory. If correct, the balance on hand will be recorded in the appropriate column on DA Form 3949-1 and the signature of these individuals will be entered in the appropriate space.

b. If the inventoried amount does not match the balance shown on the corresponding DA Form 3949, the staff will try to rectify the discrepancy. If the discrepancy cannot be corrected, the amount inventoried will be entered in the appropriate column and the discrepancy reported immediately to the next higher authority.

c. Those patient care areas operating one shift per 24 hours will not be required to maintain DA Form 3949-1. DA Form 3949 will be maintained and completed according to paragraph B-5 to the extent feasible.

B-7. Issuance of controlled substances to patient care areas

a. Issuance of controlled substances will be made only upon the receipt of a properly written and authenticated DD Form 1289 or other locally approved form. An authorized prescriber or a registered nurse will sign the form.

b. Routine bulk transfer of controlled substances between patient care areas is not authorized. Emergency transfers, when necessary, will be recorded on the appropriate DA Form 3949 by an individual authorized access to the controlled substances. They will debit the receiving area and credit the transferring area.

B-8. Disposition of surplus, contaminated, or deteriorated controlled substances by patient care areas

Controlled substances that are in excess of current requirements, contaminated, or deteriorated will be returned to the pharmacy using DD Form 1289, DA Form 3161 (Request for Issue or Turn-in), or another locally approved form. A pharmacy representative will record the turn-in transaction on the DA Form 3949 as follows.

a. Enter the day, the hour, and write 'turn-in' in the 'patient's name' column.

b. Enter the document number in the 'ordered by' column.

c. The pharmacy representative will sign his or her name in the 'administered by' column.

d. The quantity of medication turned in will be entered in the 'expenditures' column.

- e. The individual turning in the controlled substance will acknowledge the turn-in by entering his or her initials in the 'receipts' column.
- f. The new balance will be entered in the 'balance' column.
- g. The pharmacy representative will then sign the document with his or her name, rank or grade, SSN, the date, and the hour. The document will be filed in the pharmacy.

B-9. Disposition of contaminated or deteriorated controlled substances by pharmacies

- a. Whenever controlled substances have deteriorated or have been contaminated and are not usable for the purpose originally intended, are of questionable potency, or have had their identity compromised, they are reported to the medical facility commander or designated representative for a determination of disposition.
- b. Whenever controlled substances are to be destroyed, destruction is accomplished in the presence of a witnessing officer and according to the requirements of AR 40-61. A record of such destruction, signed by the witnessing officer, is filed in the controlled substances file as authority for dropping the items from the records of the accounts. Full and partial units of issue are turned in to the MSO for destruction as appropriate.

B-10. Instructions for monthly inventory and audit of controlled substances

- a. *Preliminary actions.*
 - (1) If the inventory cannot be completed within the specified period in the appointing orders, it should be reported to the appointing authority and approval obtained for a new suspense date.
 - (2) The inventory officer(s) should coordinate with the Chief, Logistics Division for inventory and audit of installation stocks. The list of activities to be inventoried should be verified through the Logistics Division and Pharmacy Service. Direct coordination with custodians of controlled substances is authorized and encouraged so as to preclude any disruption to normal activities.
- b. *Documentation of inventory.*
 - (1) *Annotation.* Entries found to be correct are annotated 'inventoried and found correct' with the date, signature, and rank or grade of the inspecting officer on the line immediately below the last entry.
 - (2) *Documentation of discrepancies.*
 - (a) In the event a quantity other than that indicated on accounting records is actually on hand and no discrepancies are found in the balance column, the quantity found is recorded as the new balance with the notation, 'per inventory,' and the date, signature, and rank or grade of the inspecting officer on the line immediately below the last entry.
 - (b) Every attempt is made to resolve all discrepancies at the time of inventory. If overages or shortages cannot be resolved, the area supervisor and Chief, Pharmacy Service are notified. Discrepancies are also reported in the final report to the MTF commander with identifying data and recommendations. The commander will take appropriate action.
 - (c) If no discrepancies were found upon completion of the required inventory and audit, a statement to that fact is reported in the final report to the MTF commander.
- c. *Procedures for the logistics division.*
 - (1) The purpose of the monthly audit of Logistics Division vault records is to ensure that records on vault items are accurate and that there is an audit trail of all receipts, issues, and adjustments on vault items. This is accomplished by:
 - (a) Ensuring that balances on the DA Forms 1296 (Stock Accounting Record) in the vault match the physical quantity of the item on hand in the vault. Figure B-3 contains a sample of a completed DA Form 1296.
 - (b) Ensuring that the balances on the DA Form 1296 in the vault match the quantity on hand on the stock control record in the Inventory Management Section.
 - (c) Ensuring that every vault item reported as shipped by a supplier was recorded on the vault records.
 - (d) Ensuring that every item that was issued to customers of the Logistics Division was picked up on the customer's controlled substance records.
 - (e) Validating that all other transactions (destruction, inventory adjustments, transfers out) that decreased the on-hand balance have supporting vouchers in the vault.
 - (2) The Chief, Logistics Division, will furnish the following documents to the inventory officer:
 - (a) Inventory count list.
 - (b) List of vault items reported shipped from that activity's supplier(s) during the previous month.
 - (c) The last monthly transaction register for vault items (automated accounts only).
 - (d) A list (preferably automated) of all issues of vault items to customers during the past month.
 - (3) MACOMs will publish detailed procedures for the monthly audit of controlled substances for each of their automated medical supply systems. These uniform procedures will be used by each of the medical activities within the MACOM to ensure that there is no abuse in the management of controlled substances. These procedures will be established to further the purposes for the audit contained in paragraph c(1) above and will include as a minimum:
 - (a) Physical inventory of all controlled substances.
 - (b) Reconciliation of the physical inventory count with the balance on DA Forms 1296 located in the vault.

- (c) Reconciliation of DA Forms 1296 balances with the stock control record balances.
 - (d) Proper inventory entries on the vault DA Forms 1296.
 - (e) Reconciliation of shipping reports from suppliers with vault DA Forms 1296 to ensure all items were received and posted.
 - (f) Reconciliation of DEA order forms with vault DA Forms 1296 to ensure that all local purchase items were received and posted.
 - (g) Reconciliation of all transactions other than issue transactions that decrease on hand balances on the DA Forms 1296 with supporting vouchers (that is, destruction, transfers out, and inventory adjustments).
 - (h) Reconciliation of automated issue or listings or issue documents with customer controlled-substances records to ensure that all items reported as issued were reflected on customer records.
- (4) See AR 40-61 for additional procedures on the management of controlled medical items.
- d. Procedures for pharmacies.*
- (1) Request from the custodian of controlled substances the following records:
 - (a) All DA Forms 3862 or AAAR printouts. These forms are used to record all transactions affecting the status and accountability of controlled substances. Figure B-4 contains a sample of a completed DA Form 3862.
 - (b) Document file, containing all documents (except prescriptions), supporting credits and debits entered on DA Form 3862 or the AAAR. It includes requests, adjustments, reports of survey, destruction certificates, turn-in documents, and copy of transfers of accountability.
 - (c) Prescription files for all controlled substances.
 - (2) Verify that DA Forms 3862 or AAAR were properly reconciled the preceding month and that the required 'findings' entry was made on each record.
 - (3) Using the tabulation of issues obtained from the Logistics Division records and all direct issues from the Prime Vendor, verify that all issues to the pharmacy service have been properly entered as receipts on the applicable DA Form 3862 or AAAR.
 - (4) Select at least 10 percent of the issues (credits) for all controlled substances recorded on each DA Form 3862 or AAAR since the last inventory and verify that each entry is supported by valid prescriptions. The prescription and the document number, authorized location, the name and strength of drug, and the amount issued or dispensed should be verified.
 - (5) Without referring to the amount shown in the 'balance on hand' column of the DA Form 3862 or AAAR, conduct a physical inventory of all controlled substances on hand.
 - (6) Referring to the appropriate DA Form 3862 or AAAR inventoried, determine if the amount physically counted reconciles with the amount reflected under the 'balance on hand' column.
 - (a) If no discrepancies are noted, the inventory officer will annotate on the next unused line of each DA Form 3862 inventoried or annotate the AAAR with the following entry: the date; the statement, 'inventoried and found correct;' the signature and rank or grade of the individual conducting the inventory; and the balance on hand.
 - (b) If a quantity other than that indicated is actually on hand and no discrepancies are found in the balance column, the quantity found is recorded as the new balance with the notation 'per inventory,' and the date, the signature and rank or grade of the individual conducting the inventory on the line immediately below the last entry.
 - (7) After verification of records, the inventory officer will tabulate all issues and turn-ins of controlled substances for activities supported by the pharmacy or obtain the AAAR listing for each activity. Tabulations will be included in a report made to the MTF commander.
- e. Procedures for patient care areas such as wards and clinics.*
- (1) The inventory officer will request from the representative in charge of the controlled substances in the ward, clinic, or other activity the following records:
 - (a) *DA Form 3949.* One form for each controlled substance line item stocked.
 - (b) *DA Form 3949-1.* All forms completed since the previous inventory.
 - (2) Verify that all DA Forms 3949 and/or DA Forms 3949-1 were properly reconciled the preceding month and that an appropriate entry was made on each form.
 - (3) Verify all of the issues and turn-ins have been properly entered on the applicable DA Form 3949.
 - (4) Without referring to the amount shown on the 'balance' column of the DA Form 3949, conduct a physical inventory of all controlled substances in the storage cabinet.
 - (a) If no discrepancies are found as a result of the above checks, proceed to certify each DA Form 3949 by entering on the next available line, the date; the hour; the statement, 'inventoried and found correct'; the signature; rank or grade of the individual conducting the inventory; and the balance on hand as determined by the inventory.
 - (b) If a quantity other than that indicated is actually on hand and no discrepancies are found in the balance column, the quantity found will be recorded as the new balance with the notation 'per inventory.' The date, the hour, the signature, and rank or grade of the inventory officer is recorded on the line immediately below the last entry.
 - (5) If a DA Form 3949-1 is maintained, enter-on the far right of the last used line-the applicable date, the shift when the inventory was conducted (for example, if the inventory was conducted at 1000, it would be the DAY shift; if it was

STOCK NUMBER 6505-00-147-8347 SCC										STOCK NUMBER SCC									
DATE	DODAAC	DATE		DEMAND		GAIN	LOSS	BALANCE	DATE	DODAAC	DATE		DEMAND		GAIN	LOSS	BALANCE		
		SERIAL	RECUR	NON-RECUR	RECUR						NON-RECUR	SERIAL	RECUR	NON-RECUR					
6005								BALANCE BROUGHT FORWARD ▶ 20											
6010	S9M	6025				5		25											
6018	PHB	6018	5				5	20											
6028	KVY	6028	2				2	18											
2 FEB 96 INVENTORY CORRECTED AND MON MON 97																			
6035	S9M	6025				10		28											
BALANCE CARRIED FORWARD ▶																			

SUMMARY OF DEMANDS

MONTH																	
RECUR	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
NON-RECUR	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/

STOCK ACCOUNTING RECORD
 FOR USE OF THIS FORM, SEE DA PAM 710-2-2. THE PROponent AGENCY IS ODCSLOG
 DA FORM 1296 JAN 82 Edition of Aug 55 is obsolete.

STOCK ACCOUNTING RECORD

6505-00-147-8347

Figure B-3. Sample completed DA Form 1296

(2) *Item 2.* Library standard address number. This number is available for each Army library. Each library is assigned a number. This number is not the same as the library identifier (LIBID) assigned by the NLM.

(3) *Item 3.* Library property account number. This is the identifying serial number assigned to a library or technical processing center. USAMEDCOM general libraries are assigned a library property account number rather than a DODAAC.

(4) *Item 4.* Library type. Enter the appropriate library type code(s). If a consolidated library, explain types of libraries involved in consolidation/merger in Section V, Narrative.

(5) *Item 9.* Library staff. Report the number, GS-series and rating of full-time equivalent employees, part-time employees, assigned military, other (specify NAF, contract, etc.), and vacant positions as of 30 September.

(6) *Item 10.* Service units/facilities.

(a) *Number of hours open weekly (staffed).* This is the number of hours that the library is staffed by an employee of the library.

(b) *Total attendance annually.* The easiest way to estimate attendance is to do a random sample several times a year. Choose a week at various times of the year and record the number of people using the library. Take an average of the number of weeks counted and multiply by 52 to get the annual count.

(c) *Net area in square feet assigned to library.* This is the total space allocated to accomplish the library's mission in square feet. It consists of the sum of all areas on all floors of the buildings that have been assigned to or are used for library functions. It includes space for readers and reading areas; bookstack and related storage areas for the book collections, audiovisual materials, and other materials; working spaces for staff and space for services to users.

(d) *Total linear feet of shelving collection.* The total amount of shelving available for the library materials is determined by adding the length, in feet, of all of the shelves in the bookstack sections and other materials sections. Only the shelves used for shelving the collection should be counted. It does not include shelves for materials-in-process, such as the technical services area, staging or storing shelves in the circulation area, or shelves for indefinite loan libraries in office areas, etc.

(e) *Seating capacity.* This is the number of seats available for the library customers.

(f) *Item 10a. Main libraries.* This is the central library.

(g) *Item 10b. Branch libraries.* These are administered from the main library and are not autonomous. They are characterized by the following: Quarters separate from the main library, a permanent collection of materials, a permanent staff provided by the main library or organization of which the library is a part, and a regular schedule for opening.

(h) *Item 10c. List library hours.* List the hours of operation, for example, Monday-Friday, weekends, and holidays. Indicate number of customer hours and non-customer hours per week. Use the nearest whole hour; omit fractions.

(i) *Item 10d. After-hours access.* If yes, indicate method of access: AOD, key, badge, etc.

(j) *Item 10e. Accreditation of library or parent organization.* Most USAMEDCOM libraries, including the patients' libraries, should indicate accreditation by the JCAHO. This accreditation comes from the accreditation of the hospital. General libraries, the AMEDD C&S Stimson Library, and the USACHPPM Library are not accredited by the JCAHO, but may be accredited by other agencies. Spell out the name of the agency; do not use acronyms.

b. Section II-Collection and expenditures.

(1) *Item 11. Collection.* In the appropriate column, report the total number of volumes/volume equivalent of shelved books and periodicals in print, microform, and electronic format. Collection definitions are as follows:

(a) *Volumes.* A physical printed unit contained in one binding/portfolio, hardbound or paperbound, that has been cataloged, classified, and made ready for use.

(b) *Volume equivalent.* The paper equivalent in another medium, such as microform or compact disk.

(c) *Periodical volume.* The publisher's volume (that is, the unit established by the publisher as a volume). A periodical volume may or may not correspond to 1 year's issue of a title; for example, the Journal of the American Medical Association, v.430 and 431, are two periodical volumes.

(d) *Electronic volume.* Machine readable serials, monographs, or databases in electronic form, such as compact disk, magnetic disk, or magnetic tape which are designed to be processed by a local computer (for example, CD-ROM subscriptions to individual electronic journals or books). Do not include titles in which a floppy disk is included as part of a book or journal. Do not include online products such as OCLC or DIALOG.

(2) *Item 11b. Periodical holdings.* This includes the total number of volumes.

(3) *Item 11e. Books purchased in FY.* This includes the total number of books purchased for the library collection, but excludes the books purchased for indefinite loan collections reported in Item 12b.

(4) *Item 11g. Other materials.* Include all other types of materials not included in any of the other previously reported categories, such as manuscripts, etc. Specify type(s) of material in Section V, Narrative.

(5) *Item 11h. Audiovisual (AV) materials.* Specify type(s) of material in Section V, Narrative.

(6) *Item 12. Indefinite loan collections.* This includes materials which are a part of the library collection, but are located outside the main library on semi-permanent/indefinite loan. Report the number of active accounts, number of items on loan, and the number of books purchased or processed for indefinite loan collections in the FY.

(7) *Item 13. Budget/expenditures.*

(a) *Item 13a. Books.* Report expenditures for books, pamphlets, reports, documents, etc. Include rental collections. The cost of materials provided from centrally-held funds (for example, book kits) should not be included.

(b) *Item 13b. Periodicals.* Report expenditures for current subscriptions in the FY.

(c) *Item 13c. Commercial electronic media.* Report expenditures for materials considered part of the collection, whether purchased or leased, such as CD-ROMs and magnetic tapes/disks that are designed to be processed by a computer, for example, MEDLINE or reference tools on CD-ROM, tape, or disk. Do not include hardware. Exclude expenses for library system software and microcomputer software used only by the library staff (reported in Section II, 13i).

(d) *Item 13d. Microform materials.* Report expenditures for materials that have been photographically reduced in size for storage and protection purposes.

(e) *Item 13e. Audiovisuals.* If cataloged and incorporated into the library's collection, include all materials which are produced to be viewed and/or heard through the use of special equipment. This does not include computer/electronic media files or printed material photographically reduced in microform. Local policy may dictate that the library does not control/maintain audiovisuals.

(f) *Item 13f. Other.* Report expenditures for other materials not reported in above categories.

(g) *Item 13h. Preservation/binding.* Report expenditures for the binding, rebinding of any library materials, printing costs, etc.

(h) *Item 13i. Furnishings, equipment.* Report costs for purchase, rentals, and maintenance of all other furnishings and equipment, except computer and preservation equipment. This includes audiovisual equipment, equipment used with microforms, and extraordinary non-recurring equipment expenditures.

(i) *Item 13j. Computer hardware, software, supplies.* Report expenditures from the library budget for computer hardware and software used to support library operations, whether purchased or leased. Include expenditures for maintenance. Exclude commercial electronic media (CD-ROMs, magnetic tapes/disks) that are designed to be processed by a computer.

(j) *Item 13k. Bibliographic utilities, networks, consortia.* Include dues, fees, and operating expenses (not reference-related expenses).

(k) *Item 13l. Contract costs.* Report expenditures for contracts with library and non-library agencies. Do not include expenditures for computer contracts or for any contracted services already reported (books, subscription services). Include interagency and cooperative costs. Include FEDLINK, DIALOG, BRS, etc., if procured by contract.

(l) *Item 13m. Civilian salaries, include benefits.* This information is available from local resource management offices.

(m) *Item 13n. Contract employee salaries.* This information is available from local resource management offices.

(n) *Item 13o. Training costs.* This includes TDY, training, conferences, etc. Includes tuition, books, travel, and per diem costs. This figure can be obtained from TDY orders of DD Form 1556 (Request, Authorization, Agreement, Certification of Training and Reimbursement).

c. *Section III-Loan transactions, services, and network participation.*

(1) *Item 14. Number of transactions made in direct circulation and reshelving of materials for the FY-annual circulation.* Includes all materials checked out plus those reshelved (presumably, after use in the library) as well as the routing of periodicals to users outside the library/information center. Do not count materials loaned to indefinite loan collections (reported in Section II, 12) or loaned to other libraries on interlibrary loan (reported in Section III, 15b). A daily count need not be maintained if a random sample accurately reflects the data.

(2) *Item 15. Interlibrary loans (ILL).* These are library materials received (borrowed) by the library or loaned to other libraries in response to a specific title, author, or subject request. Rental collection transactions are not included.

(3) *Item 16. List ILL systems/document delivery services used.* Examples are OCLC, DOCLINE, Carl Uncover, Information on Demand, British Library Document Supply Centre, etc.

(4) *Item 17. Tables of contents service.* This includes scanning and/or routing tables of contents and the number distributed. Calculate the number distributed by multiplying the frequency the journal is published times the number of users to whom it is routed.

(5) *Item 18. Selective dissemination of information services.* Includes current awareness searches and repetitive, structured bibliographies (manual or online) done for library users in areas of broad and specific interest and the number of profiles maintained. Report the number of profiles maintained not the total number performed annually which is reported in Item 27.

(6) *Item 19. Outreach services (clinical medical librarianship/literature attached to charts, regional services, etc.).* Explain the library services provided to customers within and outside the primary facilities served.

(7) *Item 22. Number of reference transactions.* These are transactions which call for professional library staff skill in locating and supplying information from inside or outside sources, analysis or interpretation of literature, selection and assemblage of library materials to answer an inquiry, and/or acting as a clearinghouse for referrals to other expert

sources. These transactions may involve, but are not limited to, extensive research. Do not include reference transactions involving only online/CD-ROM/OPAC searches (reported in Section IV, 27a-c).

(8) *Item 24. Identify networks/cooperative arrangements/consortia actively used (local/State/regional/Federal).* Medical libraries report by region number and name of servicing regional medical library (for example, the National Network of Libraries of Medicine, AMEDD MEDLI-NET, FEDLINK, OCLC, DTIC, etc.).

d. Section IV-Online services/automation.

(1) *Item 25.* List databases available for use by the library's clientele, (for example, online, CD-ROM products, and the Internet such as the NLM/Grateful Med, MEDLINE on CD-ROM (including vendor's name), Information Access Company-Health Reference Center on CD-ROM/WWW, etc.).

(2) *Item 26.* Identify database systems available through the librarian (staff-mediated searching). Database retrieval services via online, CD-ROM, and the Internet such as NLM/MEDLARS, DIALOG, OVID Technologies MEDLINE (CD-ROM and/or WWW), Information Access Company-Health Reference Center (CD-ROM and/or WWW), etc.

(3) *Item 27.* Number of staff-mediated searches for the library's clientele. Count includes all online access points (that is, each database searched). If you are using online services from another library, note which library is providing this service in the Section V, Narrative.

(4) *Item 28.* Number of searches by library's clientele. A daily count need not be maintained if a random sample accurately reflects the data.

(5) *Item 31.* List expert knowledge systems available (decision support software) such as ADAM and ILIAD.

e. Section V-Narrative. Use this section for amplification of library activity, accomplishments, etc., during the report period. Cover the following areas: personnel changes, facility improvement, library initiatives, and goals and objectives.

Appendix D Management Control Evaluation Checklist

D-1. Function

The function covered by this checklist is Medical, Dental, and Veterinary Care.

D-2. Purpose

The purpose of this checklist is to assist in evaluating the key management controls listed below. It is not intended to address all controls.

D-3. Instructions

Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, interviewing, sampling, or simulation). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These key management controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R (Management Control Evaluation Certification Statement).

D-4. Test questions

a. The Army Organ Transplant and Organ/Tissue Donation Programs. Processes for organ and tissue donation are reviewed at the triennial JCAHO review with the standards outlined in the current JCAHO manual.

(1) Did the MTF commander ensure compliance with the DOD and Army policy on organ and tissue donation?
(2) Did the MTF commander-in collaboration with the Chief, Army Organ Transplant Service-ensure that staff as well as patient education regarding organ donation was provided at each MTF?

(3) Was an MOA established with the local OPO that addressed-

(a) The mandatory notification to the OPO of potential donors.

(b) That the OPO will obtain consent.

(c) That recovery services are performed according to the 1986 update of the Uniform Anatomical Gift Act and this regulation, and

(d) That efforts were made to include the local OPO in the education process of both staff and patients?

(4) Were voluntary MOAs established with the MTCs and local OPOs to implement the military donor system?

(5) Did all AD personnel that became living organ donors meet all criteria outlined and was approval obtained from the commanding officer and the OTSG?

(6) Were MTF policies established that met the standards for the procuring and donation of organs and other tissue as outlined in current JCAHO standards?

(7) Did each USAMEDCOM RMC ensure compliance by their subordinate MTFs by annual review of MOAs, the MTC, and the local OPO?

(8) Were organ and tissue donations made according to the laws of the State where the donation was made? The Uniform Anatomical Gift Act of 1968 and its update in 1986, as part of the Omnibus Budget Reconciliation Act (section 1138 of the Social Security Act), outlines the hospital's obligations and this has been accepted by a majority of States.

(9) Is there a mechanism in place to ensure that potential donors are recognized and that family/NOK are given the opportunity to consent? MOAs may address death chart reviews by the local OPO as one way to meet this requirement.

b. Medical Laboratory Management. The CAP and/or the JCAHO review will be the evaluation process used to evaluate the key management controls. The local medical laboratory will coordinate with the Management Control Administrator to ensure that the laboratory schedules the CAP and/or JCAHO review on the 5-year management control plan. In addition, the local medical laboratory will coordinate with its QA office and the CAP and/or JCAHO review team to ensure the review of the key controls contained herein are included in the CAP and/or JCAHO review.

(1) Does the MTF commander ensure that the DOD CLIP standards for all medical laboratories are implemented and followed and that all medical laboratories under their command and control are properly registered with the DOD CLIP Office?

(2) At installations that do not have an assigned pathologist, did the commander assign a qualified licensed physician to be the director of the laboratory?

(3) Have commanders of RMCs appointed regional medical laboratory consultants to provide oversight of proficiency testing and technical medical laboratory consultation throughout the region?

(4) Did medical laboratories implement an internal performance improvement program that demonstrated improvement in clinical laboratory services?

(5) Have procedures been implemented to ensure that laboratory-related DOD patient access and cytopathology turnaround time standards are met?

(6) Did local procedures ensure that only authorized individuals ordered laboratory tests?

(7) Were all fixed U.S. Army hospital clinical laboratories accredited by the CAP or other acceptable accreditation body on a biennial basis? Were all MTF laboratories accredited by the JCAHO biennially?

(8) Was a written quality control program in place to measure, assess, and improve the quality of cytopathology services provided? Were annual statistical QA reports of cytopathology services provided according to CLIP and accreditation standards?

(9) Are annual statistical QA reports of cytopathology services published and provided at least yearly to the next higher headquarters?

c. The U.S. Army Blood Program. Blood Program elements at each MTF are inspected by several outside agencies each year utilizing extensive checklists to determine compliance with required standards. The FDA makes a yearly, unannounced visit to each facility. Following a standardized checklist, the manufacturing process is examined to determine compliance with Federal Law. Investigators are Federal employees with the authority to recommend the revocation of an establishment's license for noncompliance with applicable law. The AABB makes biennial visits to donor centers and transfusion services. Their assessors are volunteers who-through a peer review process and available guidelines of accepted blood bank practices-review the procedures and practices of a facility and recommend improvements to the process. The CLIP applies the standards set forth by the Clinical Laboratory Improvement Act. This process reviews the operation of the entire laboratory with emphasis on how the blood bank/transfusion service fits into the integrated delivery of laboratory services. The JCAHO inspects the entire MTF. A portion of the inspection reviews the operation of the laboratory and the transfusion services to determine its integration into the total delivery of service by the health care organization. DD Form 2555 (Quarterly Blood Bank Operational Report) (DODI 6480.4) is prepared by each MTF and forwarded to the Blood Program Management Office for review. It provides statistical data to the Blood Program Manager allowing a review of the operation of each blood bank and its adherence to the sound business plans addressed in paragraph C-3a(5).

(1) Did the donor center and manufacturing locations operate in compliance with the terms of the FDA license?

(2) Did the MTF operate within the standards promulgated in Current Good Manufacturing Practices for Blood and Blood Components in 21 CFR 210, 211, 600-680?

(3) Did the MTF operate within the standards set forth by the AABB in FM 8-70/NAVMED P-5120/AFMAN 41-111 and TM 8-227-3/NAVMED P-5101/AFMAN 41-119? In addition, did blood banks and transfusion services receive accreditation by the AABB, and are they complying with requirements of the FDA, CLIP, and JCAHO?

(4) Did the blood banks and transfusion services implement a QA program to foster continuous improvement and to meet the requirements for the licensing and accrediting agencies (for example, FDA, AABB, CLIP, and JCAHO)?

(5) Did the MTF establish a sound business plan to support its blood and blood component needs? Did the plan include efforts to minimize waste (outdating) through utilization of exchange agreements with other uniformed services and local civilian institutions? Does the plan include a fair market value for products exchanged to include red blood cell components and recovered plasma?

d. Pharmacy management. The JCAHO review will be the evaluation process used to evaluate the key management controls. The local pharmacy will coordinate with the Management Control Administrator to ensure that the pharmacy schedules the JCAHO review on the 5-year management control plan. In addition, the local pharmacy will coordinate

with their QA office and the JCAHO review team to ensure the review of the key controls contained herein are included in the JCAHO review.

(1) Did the MTF commander ensure compliance with the DOD Tri-Service pharmacy policy guidance for dispensing medications?

(2) Did pharmacy services ensure that only qualified persons compounded and/or dispensed pharmaceutical preparations?

(3) Did pharmacy services implement an internal performance improvement process that demonstrated improvement in pharmacy services?

(4) Did local procedures ensure that only authorized individuals wrote medication orders and/or prescriptions?

(5) Except for the physician order entry via the CHCS, did local procedures ensure that no prescription or order was filled in the pharmacy unless it bore the signature of an individual authorized to prescribe medications?

(6) Did local procedures ensure that the guidance for inventory, control, and accountability of controlled substances was accomplished in accordance with appendix B?

e. Army Aviation Medicine Program.

(1) Has the RMC commander established procedures to ensure that the AVMED program is implemented?

(2) Has the Commander, U.S. Army Aeromedical Center established procedures to ensure worldwide support of Army AVMED programs through consultations, supportive services, and training in the areas of aviation and military occupational disease prevention, surveillance, and evaluation?

(3) Has the installation medical authority having aviation assets assigned to the installation established, supervised, administered, and supported the AVMED program?

f. Army Medical Department Medical Libraries and Information Centers.

(1) Is DA Form 7397-R completed and submitted annually by 31 Oct to the Commander, USAMEDCOM (MCHO-CL), 2050 Worth Road, Fort Sam Houston, TX 78234-6010?

(2) Is there compliance to the interlibrary loan standards established by the NLM and/or the American Library Association?

(3) Is an inventory record (manual or electronic) maintained as the official record of accountable library materials as required by AR 735-17?

(4) Is a physical count of the library collection conducted and documented every 3 years as required by AR 735-17?

D-5. Supersession

There were no previous checklists.

D-6. Comments

Help make this a better tool for evaluating the Medical, Dental, and Veterinary Care process. Comments regarding this checklist should be addressed to: Commander, USAMEDCOM (MCHO-CL), 2050 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

Glossary

Section I Abbreviations

AAAR

approved automated accounting record

AABB

American Association of Blood Banks

AASC

U.S. Army Audiology and Speech Center

ACIP

aviation career incentive pay

ACLS

Advanced Cardiac Life Support

AD

active duty

ADA

American Dietetics Association

ADCS

Army Dental Care System

AME

aviation medical examiner

AMEDD

Army Medical Department

AMEDD C&S

Army Medical Department Center and School

AMEDD MEDLI-NET

Army Medical Department Medical Library and Information Network

APLS

Advanced Pediatric Life Support

ASBPO

Armed Services Blood Program Office

ASD(HA)

Assistant Secretary of Defense (Health Affairs)

ASWBPL

Armed Services Whole Blood Processing Laboratory

ATLS

Advanced Trauma Life Support

AVMED

aviation medicine

BCF

Basic Core Formulary

B DFA

Basic Daily Food Allowance

BHTC

basic hearing test clinic

BLS

basic life support

CAMI

Civil Aeromedical Institute

CAP

College of American Pathologists

CFR

Code of Federal Regulations

CHAMPUS

Civilian Health and Medical Program of the Uniformed Services

CHCS

Composite Health Care System

CLIP

Clinical Laboratory Improvement Program

COLA

Commission on Office Laboratory Accreditation

CONUS

continental United States

DA

Department of the Army

DDC

Denver Distribution Center

DDS

director of dental services

DEA

Drug Enforcement Administration

DNR

do-not-resuscitate

DOD

Department of Defense

DODAAC

DOD Activity Address Code

DOFC

Defense Orthopedic Footwear Clinic

DTF

dental treatment facility

EC

emergency center

EMS

emergency medical services

EMT

emergency medical technician

EMT-B

emergency medical technician-basic

EMT-I

emergency medical technician-intermediate

EMT-P

emergency medical technician-paramedic

FAA

Federal Aviation Administration

FDA

Food and Drug Administration

FDME

flying duty medical examination

FS

flight surgeon

FY

fiscal year

GOA

Government-owned animals

HREC

health record

IOP

improving organizational performance

ITR

inpatient treatment record

JCAHO

Joint Commission on Accreditation of Healthcare Organizations

LC

Library of Congress

MACOM

major Army command

MEDCEN

U.S. Army medical center

MEDDAC

medical department activity

MHS

Military Health System

MLA

Medical Library Association

MOA

memorandum of agreement

MOS

military occupational specialty

MPT

medical proficiency training

MSAO

medical services accountable officer

MSO

medical supply officer

MTC

Military Transplant Center

MTF

military treatment facility

MWD

military working dog

MWH

military working horse

NAF

nonappropriated fund

NBE

National Blood Exchange

NCD

Nutrition Care Division

NLM

National Library of Medicine

NMIS

Nutrition Management Information System

NMOP

National Mail Order Pharmacy

NOK

next of kin

NP

nurse practitioner

NREMT

National Registry for Emergency Medical Technicians

OCLC

Online Computer Library Center

OPLANS

operations plans

OPO

Organ Procurement Organization

OPTN

Organ Procurement and Transplantation Network

OT

occupational therapist

OTC

over-the-counter

OTR

outpatient treatment record

OTSG

Office of The Surgeon General

PA

physician assistant

PALS

Pediatric Advanced Life Support

PASBA

Patient Administration Systems and Biostatistics Activity

PDS

Pharmacy Data Transaction Service

POA

privately-owned animals

PPM

provider-performed microscopy

PT

physical therapist

P&T

pharmacy and therapeutics

RAM

residency trained aerospace medicine

RC

Reserve Component

RMC

Regional Medical Command

ROES

Remote Order Entry System

SIK

Subsistence in Kind

SSN

social security number

TB MED

Technical Bulletin, Medical

TDA

table(s) of distribution and allowances

TDY

temporary duty

TISA

Troop Issue Support Activity

TOE

table of organization and equipment

TPCP

Third Party Collection Program

TSF

TriService Formulary

TSG

The Surgeon General

USACHPPM

U.S. Army Center for Health Promotion and Preventive Medicine

USAMEDCOM

United States Army Medical Command

USAMRMC

U.S. Army Medical Research and Materiel Command

USC

United States Code

VA

Department of Veterans Affairs

VTAT

veterinary training assistance team

Section II**Terms****A La Carte Meal Service**

A system in which a variety of food items are available and the individual selects those food items desired.

A La Carte Meal Pricing System

Each menu item is priced separately, based on its food cost (including an applicable condiment percentage factor) plus a proportional charge for related operating costs determined annually by the DOD Comptroller.

Abatement order

A written order for DNR (or 'no-code') or to withdraw or withhold life-sustaining treatment.

Active duty

Full-time duty in the active military service of the United States. It includes Federal duty on the active list (for National Guard personnel), full-time training duty, annual training, and attendance, while in the active military service, at a school designated as a service school by law or the Secretary of the military department concerned.

Adult

A person 18 years or older, emancipated minors (as determined by State law), and members of the armed forces.

Advance directive

A written document defining a patient's wishes, should (s)he become incapable of participating in medical decisions. These include a 'Durable Power of Attorney for Health Care' and a 'Living Will.' State law governs the validity of these documents.

Aeromedical physician assistant

Physician assistants who successfully complete the Army Flight Surgeon Primary Course.

AMEDD MEDLI-NET

The electronic network of AMEDD libraries and information centers that ensures timely and cost-effective access to biomedical information and services to all echelons of the AMEDD worldwide. The goal of the AMEDD MEDLI-NET is to provide the highest quality, customer-oriented, knowledge-based information programs and services in support of patient care, health care administration, research, education, training, and readiness.

Authorized Monetary Value Allowed for Subsistence

NCD earnings equal patient meal days multiplied by the patient BDFA plus non-patient meal days multiplied by the MTF BDFA. NCD earnings in an a la carte operation equals the patient meal days multiplied by the patient BDFA plus SIK meal days multiplied by the MTF BDFA plus cash collected (less operating costs). The authorized monetary value allowed for subsistence or earnings is calculated on a daily basis to provide a 'yardstick' to compare with the monetary value of food purchases.

Aviation Medicine Program

An integrated, multi-disciplinary program of primary care, preventive medicine, and occupational health for aviation personnel.

BDFA

The authorized monetary value of a meal day furnished by non-MTF dining facilities.

Box meal

Meal sold to personnel authorized to subsist in NCD who are unable to eat in the dining room.

Clinical laboratory

A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purposes of providing information for the prevention, diagnosis, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service, and not performing testing, are not considered clinical laboratories.

Clinical specialty

Any medical specialty excluding pathology, psychiatry, nuclear medicine, preventive medicine, occupational medicine, physiatrics, and radiology.

Decision making capacity

A patient with decision-making capacity is an adult who has the ability to communicate and understand information and the ability to reason and deliberate sufficiently well about the choices involved.

Donor card

A legal document signed by an individual properly witnessed under the rules of informed consent, and indicating a desire to have one or more organs and/or tissues removed at death for donation to another individual.

DNR Order

A written order suspending the otherwise automatic initiation of cardiopulmonary resuscitation, that is, any means used

to support ventilatory and/or circulatory function until spontaneously resumed or until artificial means are established or until the patient is pronounced dead.

Durable power of attorney for health care

A written document designating a surrogate. This is a type of advance directive.

Emergency

Situation that requires immediate intervention to prevent the loss of life, limb, sight, or body tissue, or to prevent undue suffering.

Emergency center

The designated area in a nondeployed MTF having the personnel and resources required to provide patient care emergency services at level I, II, or III of care as defined by this regulation.

Emergency medical services

The resources-both personnel and facilities-that are available 24 hours a day to assess, treat, or refer for medical and/or dental treatment, an ill or injured person. The level of EMS at a fixed MTF shall be classified as level I, II, III according to JCAHO standards and the requirements of this regulation. EMS refers to prehospital emergency services to include aeromedical evacuation-and fixed facility emergency services.

EMS health care providers

Physicians, dentists, NPs, and PAs granted clinical privileges to provide emergency patient care. This includes DOD military and civilian personnel as well as contractual personnel.

EMS nurse

A registered nurse who is assigned to the EC, has a minimum of 1 year of inpatient hospital experience, and has current ACLS.

EMS physician

A physician who is assigned to the EC and fulfills the educational, training, and experience requirements of this regulation.

Emergency medical technician

Hospital medic, corpsmen, or technician (military or civilian) who is assigned to the EC and/or ambulance duty and is trained according to DOT curriculum or equivalent program approved by NREMT.

Ethics committee

A multidisciplinary committee that can assist in resolving ethical concerns pertaining to medical treatment decisions. This committee can assist all parties in identifying ethical issues, defining their positions, and resolving potential areas of conflict.

Federal Library and Information Network

An interagency cooperative program sponsored by the Library of Congress and the Federal Library and Information Center Committee. It offers any Federal library or information center service contracts directly from commercial vendors for information or operations support services including online reference databases, online cataloging and interlibrary loan services of bibliographic utilities, and ordering and publications control services of book jobbers and serials subscription agents. These contracts usually provide substantial discounts to the library or information center.

Fixed MTF

A permanently established land-based medical facility excluding ships, field units, and air-transportable hospitals.

Incapable patient

A minor or someone who does not have the ability to communicate or understand information or to reason and deliberate sufficiently well about the choices involved. Some exceptions have been created for 'mature' minors between the ages of 14 and 17 years in recognition that children sometimes have adequate capacity to make decisions. However, a minor below 14 years old will be considered to lack capacity for health care decisions, unless specifically so provided by applicable State law. This incapacity should be verified by clinical assessment of mental and emotional status.

Indefinite loan collections/libraries

Any size collection of library materials loaned to a department for use on a daily basis. The materials are part of the

main library's total collection and signed out to the department's indefinite loan accountable officer on DA Form 3161. Materials on indefinite loan are subject to recall for use by other library users.

Investigational drug

A drug not yet approved by the FDA for routine use by the public as a safe and efficacious drug.

Knowledge-based information

Commonly referred to as 'the literature,' knowledge-based information includes journal literature, reference information, and research data. It is authoritative and up-to-date. It supports clinical decision making, continuing education of staff, administrative planning and management, performance assessment and improvement, patient and family education, and research. Systems, resources, and services are necessary to effectively and efficiently manage knowledge-based information. Systems refer to the structures needed to identify, locate, and control knowledge-based information, that is, electronic and paper-based catalogs, networks, consortia, controlled vocabularies, and standard nomenclatures. JCAHO has identified knowledge-based information as vital to an organization's ability to provide patient care.

Living will

A written document setting forth a person's desires concerning medical care when (s)he is terminally ill or in a persistent vegetative state. This is a type of advance directive.

Lunch

The meal served during midday and considered the second meal of the day.

Meal day

The quantity of nutritionally adequate subsistence (food) furnished to one person during a 24 hour period (0001 to 2400 hours).

Meal days served

Meal days served is determined each day by multiplying meals served by the appropriate conversion factor (weight) for each meal period and then adding patient census. These figures are then posted to rations earned on the DA Form 1836.

Meals served

Aggregate number of meals furnished by NCD for all dining situations (for example, dining room, ward meals served, box meals) for a prescribed period of time.

Medical care

Unless otherwise specified, medical care includes, but is not limited to the following:

- a. Inpatient treatment.
- b. Outpatient treatment.
- c. Nursing care.
- d. Medical examinations.
- e. Immunizations.
- f. Drugs.
- g. Subsistence.
- h. Transportation.
- i. Other adjuncts such as prosthetic devices, spectacles, hearing aids, and orthopedic footwear. This includes appliances such as braces, walking irons, and elastic stockings.

Medical treatment facility

A civilian or uniformed services medical center, hospital, clinic, or other facility that is authorized to provide medical, dental, or veterinary care.

Medication errors

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

MTF BDF

The authorized monetary value of a meal day furnished by the MTF to a non-patient.

Next of kin (primary)

The available interested party highest in the order of priority in a through f below. The designated NOK may waive all referenced rights for organ disposition in favor of the next interested party in the order of priority.

- a. The spouse of the donor.
- b. An adult son or daughter of the donor.
- c. Either parent of the donor.
- d. An adult brother or sister of the donor.
- e. A grandparent of the donor.
- f. A guardian of the donor at the time of death.

Nutrition support team

An interdisciplinary team concerned with aggressive nutrition support of patients requiring enteral/parenteral nutrition.

Official functions

Functions which further the successful completion of the MTF mission or operation.

Organ

Includes heart, lung, liver, kidney, pancreas, or any other organ that is currently or in the future deemed suitable for transplantation.

Organ donor

An individual who makes a gift of all or part of his or her body for use after death for specific purposes.

Organ Procurement Organization

A formally constituted civilian organization created to coordinate and recover organs and tissues for a specific type of transplantation or a special geographic area.

Other Food Service Support

Provision of food items for purposes over and above the traditional meals and nutrition support provided for patients and authorized patrons.

Other psychological test users

Individuals who choose tests, interpret scores, make decisions, make dispositions, render reports, or who conduct experimental studies, based on test scores or results.

Patient BDFFA

The authorized monetary value of a meal day furnished by the MTF to an inpatient. The patient BDFFA is determined by multiplying the MTF BDFFA by 1.15 (an increase of 15 percent).

Patient with decision making capacity

An adult (18 years of age or over or emancipated minor as determined by State law) who has the ability to communicate and understand information and the ability to reason and deliberate sufficiently well about the choices involved. Some exceptions have been created for 'mature' minors in recognition that children sometimes have adequate capacity to make decisions. However, a minor below 14 years old will be considered not to have capacity for health care decisions, unless specifically so provided by applicable State law. Emancipated minors include 17 year old service members.

Pharmaceutical care (from the Academy of Managed Care Pharmacy, Concepts in Managed Care Pharmacy series)

That component of the health care system that seeks, through the caring, collaborative efforts of a team of pharmacists, physicians, nurses, and other health care providers working with patients, to ensure that medications are used appropriately to improve patient health status.

Pharmacy data transaction service (PDTS) (from PDTS Business Rules)

Military Health System Integrated Pharmacy System business rules that identify issues and processes used by the pharmacists and providers in the direct care system when interacting with the PDTS. The integrated pharmacy system will operate with several Government systems to screen an eligible patient's prescription against the patient's total drug profile for drug interactions, drug overlaps, drug dosage, and patient compliance. Additionally, retrospective, concurrent, and prospective drug utilization reviews will be accomplished.

Protocols

Written procedures providing basic guidelines for the management (diagnosis and treatment) of specific types of medical and dental patient care emergencies.

Pre-hospital EMS

Emergency services rendered between the onset of an emergent pre-hospital event (sudden illness or injury) and arrival at the EC.

Primary care specialty

Those medical specialties of emergency medicine, internal medicine, pediatrics, and family practice.

Psychological test

Any standardized assessment device, test or inventory, designed and used for understanding and diagnosing the nature and causes of, and for predicting and reducing the following effects of, mental disorder or disturbance and physical disease or disability: subjective distress, individual impairment, and psychological and emotional factors.

a. Psychological tests focus on cognitive and intellectual abilities, aptitudes, emotions, motivations, personality characteristics, psychoneurologic functioning, academic skills and educational achievement, or other aspects of human experience and behavior.

b. The criteria used to identify a procedure as being a psychological test include that the test has been-

(1) Involved in appellate decisions of the Courts of the United States, or in the decisions of their administrative agencies, both Federal and State, that define the admissibility of clinical, counseling, school, or industrial psychologists' test results; or

(2) Developed by psychologists applying principles, methods, and procedures of the science of psychology in test construction; or

(3) Introduced to, or routinely evaluated in, professional psychological practice by publications authored by psychologists in recognized clinical, counseling, or consulting psychology or medical literature; or

(4) Listed or reviewed in authoritative references either of psychological testing and evaluation or of mental measurements classified as individual achievement, intelligence, aptitude, personality, psychology, or neuropsychology; or

(5) Obtained from vendors making known that sale is made in adherence to the ethical standards of the American Psychological Association.

c. The following types of procedures are excluded from the definition of a psychological test, as defined by this regulation:

(1) Surveys and questionnaires used in measuring group attitudes and interests.

(2) Surveys and questionnaires administered for purposes of assessing an individual patient's social relationships (that is, marital and family) or pediatric developmental milestones and schedules.

(3) Instruments solely measuring occupational interest or choice, role or skill performance, and vocational adaptation or leisure.

Psychological test direction

The technical and operational management, control, supervision, instruction, and guidance of the actions of individuals, or of the operations of services, pertaining to psychological testing. Psychological test direction includes the legal, administrative, and professional accountability for such services.

Qualified psychologist

An individual who has earned a doctoral degree from a regionally accredited university or professional school providing an organized, sequential clinical or counseling psychology program in a psychology department or unit of a professional school. The person has acquired supervised training that is directly related to the functions to be performed and services to be provided. Doctoral education programs and other professional training and internship programs accredited by the American Psychological Association, or evaluated as acceptable by the OTSG, are recognized as meeting this definition. The individual possesses a current, valid, and unrestricted State license to practice psychology independently at the doctoral level.

Surrogate

An agent, proxy, or surrogate decision maker who is designated to make medical decisions on behalf of a person who lacks decision making capacity. This surrogate has the authority to act fully on behalf of the patient and has priority over any other person to act. The identification of the surrogate may require reference to State law.

Test administration

Orally, manually, or electronically giving a test, or portion thereof, following standardized instructions.

Test scoring

The manual or electronic tabulation, compilation, or summation of derived test data in accordance with developed standards, criteria, norms, and methodology.

Tissue

Includes cornea, eye, skin, bone, bone marrow, peripheral blood stem, dura, blood vessels, fascia, or other tissue that is currently or in the future deemed suitable for transplantation.

Traditional meal pricing system

Fixed charge for a complete meal determined annually by the DOD Comptroller. Under this system, there are two meal rates for individual categories of personnel determined by the DOD Comptroller.

a. Full (standard) meal rate. A fixed charge for a complete meal that includes the cost of the food and a proportional charge for related operating costs.

b. Discount meal rate. A fixed charge for a complete meal that includes the cost of the food only.

Traditional meal service

A system in which a complete meal is served with few or no substitutions or selections available.

Withhold or withdraw order

A written order not to initiate or to discontinue (a) specific therapeutic modality(ies), including life-sustaining modalities.

Section III**Special Abbreviations and Terms**

This section has no entries.

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